The evolution of the industrial relations function in the National Health Service 1974-80.

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Award date:
1983

Awarding institution:
University of Bath

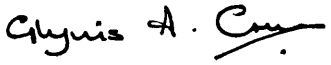
THE EVOLUTION OF THE INDUSTRIAL RELATIONS FUNCTION

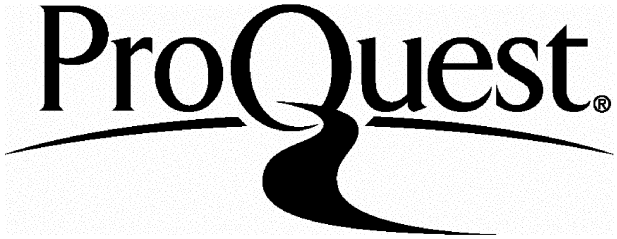
IN THE NATIONAL HEALTH SERVICE 1974-80

Submitted by Glynis A. Crum for the degree of

Ph.D. of the University of Bath

1983





Acknowledgements

I find it very difficult to adequately express my thanks to all who have assisted me in the preparation of this thesis.

The staff of South Glamorgan Health Authority, Trade Union officers and representatives, representatives of DHSS, all merit note. To them, I offer my thanks.

Specifically I would wish to mention Mr. John Taylor lately appointed District Administrator of East Dyfed Health Authority. He has offered constant advice and support throughout the duration of my work, and has maintained constructive interest in the outcome. Thank you.

I am as ever, indebted to my supervisor, Mr, Alan Baker of the University of Bath, who has suffered long! Thank you.

SUMMARY

Circular HM (72) issued by the DHSS in September 1972 set out the importance to the National Health Service of the establishment of a comprehensive approach to the development of the personnel function by the reorganised hospital authorities. The circular placed the responsibility for "effective personnel management" on the shoulders of line management and stressed the "supportive role" of the Personnel Officer. The future importance of the Industrial Relations function in the reorganised service was clearly not anticipated, and it is now evident that the demands and constraints experienced by Personnel Officers have produced important changes in the comprehensive nature of their role - in many cases industrial relations has become their primary responsibility.

The period 1974 until 1980 was one of major change and pressure, and the growing awareness of structural faults in the National Health Service. In 1975 Lord McCarthy was appointed to investigate the continued functioning of Whitley Council machinery, and in 1976 Sir Alec Merrisan was commissioned to consider the working of the National Health Services. There was an obvious concentration on structure and structural modification. The relationships both inter and intra-organisational were not always objectively considered.

CONTENTS

INTRODUCTION

INTRODUCTION

The National Health Service in Great Britain has been subjected to major changes during the period from its inception in 1948 until 1980. Whatever may be said of its strengths and weaknesses, of its structure or organisation - it remains one of the most complex employers of widely different staff groups in Europe. As such, it needs to operate systems which will maintain the organisation, and ensure contact with the environment within which it seeks to operate.

The service provision, the ethos of the organisation, requires the co-ordination of not only economic and plant resources, but the integrated efforts of staff groups often with divergent objectives. Comparisons may be made between the National Health Service and other large organisations, in the size and complexity of operation; and yet basic organisational flaws appeared to exist in the structure following the 1974 reorganisation which inevitably resulted in less than optimum economic resource utilisation.

For many years prior to 1974, the Ministry of Health's efforts were directed towards limiting the scope for local bargaining. The intent of the Whitley Council machinery was to establish uniform pay scales for staff. The independent Guillibaud Committee of Inquiry (1956) supported the Ministry of Health's policy of removing local options. Clegg and Chester (1957) recorded that:

> "the management side have been anxious to limit the powers of the Appeals Committees, lest they should grant what has been or could be refused in the National Councils".
>
> (1957)

The General Whitley Council was unable to agree on a disciplinary procedure in 1951 because the management side was unwilling to allow a greater role to devolve to the region. The Ministry issued its own "interim guidance" which was still operational until 1975. In practice the Whitley Council had difficulty in making voluntary agreements. Of the 53 major settlements in the National Health Service from 1948 to 1955, 26 were the result of arbitration. The system did not maintain pay parity for staff groups. Before 1955 only nurses received pay awards greater than the cost of living. The system depended upon the weaknesses of the unions. As Clegg and Chester observed:

> "The system might be made to work differently and to produce different results of the staff organisations could discover new means of bringing pressure to bear on the management side. Amongst the main reasons for differences in pay between the Health Service and the engineering or mining industries is that the employers in these industries fear the union more than the management side fear the health service staff organisations."
>
> (1957)

The basis of this research and the ensuing discussion is that the Personnel and industrial relations function has been the focus of little, or no sensitive planned development, the predominent stimulus being of deductive reaction epitomised in the description 'a plaything of social forces'.

The presence, indeed it may be argued, the traditional dominance of centralised policy has caused highly divergent patterns of local interpretation to emerge during the period 1974-1980. This change I have termed evolution, because it may be likened to the phenomena originally

described by Darwin (1859). Darwin considered that organism specialisation was brought about as a reaction to environmental factors. This evolutionary pattern, either 'natural selection' or 'survival of the fittest' would appear to explain the pattern of personnel development, in some contexts. However, the more recently proposed Cladistic theory (Leith 1982) offers an alternative explanation of evolution. Cladists propose that evolutionary change is not gradual and smooth, but traumatic and catastrophic. This thesis will attempt to demonstrate that the Personnel and Industrial Relations function was subjected to greater change in status and role because of major external stimuli, than continuous development in periods of 'calm'.

Burns and Stalker (1961) indicated that organic or 'dynamic' organisation structure cope much more rapidly and effectively in environments which offer stimulus than more rigid organisations. The National Health Service during the period 1974-1980 was required to change, but was not always able to maximise or even optimise - but had to compromise for survival.

Watson (1977) argued that:

"the influence of the personnel specialist is dependent on the help he can provide to the dominant coalition of the organisation in its achieving of the objectives".

The role of the personnel specialist in the National Health Service necessarily changed during the period 1974-80, particularly in the amount of Industrial Relations involvement.

This thesis will describe the nature of the organisation during the period leading up to the 1974 reorganisation and during the period 1974-1980.

Using the example of one Single District Teaching Area Health Authority, I shall then exemplify the problems of formulating rational Personnel policies under rapidly changing environmental pressures.

In 1976, the Royal Commission on the National Health Service was appointed to consider the further structural rationalisation of the service. The Commission reported in 1979, advising reorganisation, including the removal of one level of management. This precipitated specific reaction, therefore I terminated the period of study in 1980.

It may be argued that one Single District Teaching Area may not be typical, but the period of study was one in which the National Health Service was subjected to co-ordinated pressure from staff groups - an emergent trend which precipitated local reaction. In discussion with DHSS representatives and colleagues throughout the Service, I have established that organisational reactions were similar throughout Great Britian, with very few exceptions.

The Importance of the concept of Industrial Relations within the National Health Service is qualified by the following extract from the 'Grey Book':

> "the National Health Service is one of the nations' largest employers of labour, much of it highly skilled. It currently employs more than 800,000 people, 4% of the working population - and wages and salaries account for almost 70% of the total current Health Service expenditure."
>
> (1972)

Much of the philosophy of industrial relations in the National Health Service necessarily alienates some of those who are involved within it.

Many other individuals are less than totally committed to the way in which National Health Service industrial relations have evolved.

Analyses of the subject have also tended to concentrate attention on the hospital staff, as the greatest concentration of the labour force is to be found there. The particular problems related to the non-hospital based staff i.e. community health services staff often with a Local Authority employment history have not necessarily been considered within this thesis.

Bearing these caveats in mind, it has appeared quite clear that one of the major topics of consideration should be the possible changes of emphasis from centralised to localised bargaining. The possibility waivered between strong possibility and suspected probability during the period 1974-1980 in an environment of approval for greater worker participation. This proposition posed perhaps the greatest long term threat to the monolithic central core of the National Health Service - the centralised Whitley Council machinery.

The major issue of industrial relations in the National Health Service has been the ability of the Whitley Council system to respond to trends, which in turn depend upon the resolve of the partners, i.e. management, unions, and the various facets of government.

Concurrent with this was the changing role of the Health Authority, the local lay members, to whom the Chief Officers were responsible.

The changed organisational structures of the National Health Service are described in Appendix 1, in chart form, for reference.

Definitions

It will become evident throughout this thesis that the definition of industrial relations which predominates is that of the regulatory framework. This is inevitable given the mechanical organisational framework and structure of the National Health Service. The personnel officers appointed to the National Health Service in 1974 were a new category of manager, replacing the previously appointed Staff Officers whose predominant duty had been training.

The local managers, those at Unit, District and Area level, even post 1974, had great responsibility for managing the daily industrial relations of the work units.

It is anticipated that the evidence presented in this thesis will demonstrate the inherent problems of the National Health Service in trying to identify role differences and recognising mutual esteem, especially as the period under discussion was of great environmental pressure, both external and internal.

THE EVOLUTIONARY PROCESS BEFORE 1974

BACKGROUND BEFORE 1974

The trend towards local bargaining was given its most trenchant expression in the Report of the Donovan Commission on Trade Unions and Employers Associations (1968) which drew heavily on the research undertaken by Lord McCarthy. This exposed the inherent conflict between two systems of industrial relations in the United Kingdom - the formal and the informal. The formal is embodied in the official institutions and national negotiations, and the informal which is created within the work place by the behaviour of managers, shop stewards and workers. The Commission held that the two systems have very little in common with each other. The formal system assumes that most of the issues which relate to collective bargaining can be covered in industry wide agreements. The informal system however, maintains that the most important part of collective bargaining is that which takes place within the workplace. The formal system accepts that collective bargaining is concerned with achieving written agreements, the informal consists largely of the formulation of tacit arrangements and understandings, and in custom and practice. In the formal system, industrial relations within the workplace means joint consultation and the interpretation of collective agreements; in the informal, the difference between joint consultation and collective bargaining is not clearly defined.

This analysis gave rise to one of the main principles upon which the Commissions's recommendations were based, that a system of industrial relations must be judged principally by its effects within the organisation, the site and department. It was clearly time to:

"put an end to the conflict between the pretence of industry-wide agreements and the realities of industrial relations."

(Donovan Commission, 1968)

The Commission's account of industrial relations has several features of direct relevance to the National Health Service. Though the trend towards local bargaining is described with manufacturing organisations in mind, it should be accepted that the National Health Service is not immune from the influence of developments in these organisations. Employees move from one sector to another, and some unions cover both manufacturing organisations and public services. But apart from the effect of mutual influence, it may be inferred that the conflict between the formal and informal systems is present in the National Health Service in its own right.

The Whitley system is the classic institutionalised national negotiating mechanism. The difference in the National Health Service, is that not only is it formal, but that it only exists at one level - nationally. No local bargaining machinery, formal or informal, existed on a scale which Donovan may have identified in 1968. But, in that year, he would not have found the same problems at local level in the National Health Service that he found in other organisations. He did, however, give warning of what would happen if pressures arose for local bargaining, and there was inadequate machinery to respond to these.

These pressures did, in fact arise in the National Health Service particularly in the period 1974-1980. Two were a consequence of institutional factors, and had their origins in government intervention.

The first was the examination of the National Board for Prices and Incomes of the pay of hospital ancillary workers. The background to this

examination was the ambivalence of the government's role as an employer and its role as manager of the economy. These factors had caused widening differentials in earnings between the public and private sector employees.

While management and unions in key areas of private industry had been largely able to avoid voluntary and mandatory incomes policies, by non-observance, spurious productivity deals, and local wage bargaining, employees in the public sector had experienced a stricter control of earnings. The earnings of ancillary workers were the subject of two NBPI reports.

The first in 1967, indicated the large concentration of low paid, male ancillary workers and the scope for productivity improvements in local authority and hospital employment. It suggested that these problems could be mitigated by the introduction of properly constructed, self financing, incentive payment schemes. As a result, 'interim' and fully work studied schemes were slowly introduced into the ancillary sector.

Earlier research had shown that such systems have important and often unforeseen implications for work group behaviour. It is generally agreed that a causal relationship exists between payment by results and the incidence of workplace bargaining, and shop steward activity. To a great extent, the ability of the ancillary workers to involve themselves in workplace bargaining depends on:

i) the scope for bargaining

ii) work group consciousness

iii) a representative recognised as such by management

A feature of the National Health Service incentive schemes is their

tendency to foster and promote these three determinants. Initially, schemes had to be discussed with, and approved by the workers concerned. The scarcity of work study resources balanced against the low level of coverage of schemes suggested that those in operation could degenerate because of inadequate monitoring. Consequently the revision of schemes provided further bargaining opportunities. The majority of schemes were work group based, while work groups without stewards were encouraged to appoint representatives to discuss the introduction of such a scheme. Such developments were clearly conducive to the emergence of shop steward activity. All three determinants pointed towards local bargaining.

The second institutional pressure in this direction was the Industrial Relations Act of 1971, and the Code of Practice. One aspect of the Whitley machinery was its apparent failure to initiate relevant industrial relations procedures at hospital level, for example, comprehensive procedural arrangements for the resolution of locally determined disputes. Similarly, the disciplinary procedure drafted in 1951 by the Ministry of Health had remained unchanged. In consequence, after the publication of the Code of Practice, the National Health Service possessed neither a Grievance Procedure nor a Disciplinary Procedure which conformed to the Code's suggestions. In developing such procedures, shop stewards and hospital level union activity became consolidated. In the absence of practical guidance from the DHSS, it became encumbent on local management to take the initiative, often with union lay representatives, to draw up locally based grievance and disciplinary procedures.

This move towards local joint procedural arrangements constituted a significant change of direction in Health Service industrial relations. Such circumstances sharpened local managements' and workers' awareness of

industrial relations.

In addition to these two institutional pressures, three sets of environmental pressures also affected industrial relations at hospital level.

The first related to management - and was a consequence of increased professionalisation. This was a response to DHSS financial controls and increased demand for medical services. The construction of larger hospital units and the centralisation of important service functions, like laundry and supplies, were examples of a shift towards industrial orientated methods requiring more sophisticated managerial skills and awareness.

Another force acting on hospital managers was the problem of recruiting manual workers in difficult labour market conditions, particularly in urban areas. Nationally negotiated wage rates provide insufficient to attract workers to hospital employment. As a result, managers had to cope with such shortages by increasingly efficient methods of resource utilisation, their most valuable resource being labour.

A second set of environmental pressures affected hospital workers. Dimmock and Farnham (1975) found that this also has been economic in origin. A prime difficulty for many groups of hospital workers, especially ancillaries, was a decline in the purchasing power of their wages during a period of rapid inflation. At the same time, their perception of themselves in terms of their purchasing power was probably exacerbated by the growth of "market-place consumerism" creating expectations of greater consumption. Chubb and Jerome (1970) found a trend from commitment to conflict influenced by the rapid changes in technology.

"The evidence suggests that there has been a swing from a stable organisation, based primarily on vocational commitment to the hospital and its patient care goals; it is moving towards a dynamic system in which the primary motivator and unifying factor for all occupational groups is no longer the single overriding goal. It is being replaced by the intraorganisational conflict of an industrial type. By looking at certain occupational groups, we hope to see that technological changes are affecting their composition and grievance activity in this way."

(1970)

The third set of pressures was a consequence of the second, and focussed on the trade unions. Those representing ancillary workers especially had to be seen to be more effective in terms of the outcome of joint negotiations. They had to relate their own negotiating behaviour to patterns derived from private sector employment, where it had been clearly shown in preceding years that militancy produced results. The 1973 national pay dispute was possibly a turning point in the development of collective bargaining attitudes in the National Health Service. In one way, it represented a high level of union identity with workplace attitudes and feelings, conversely it marked the first official confrontation between ancillary workers and managers at the local level.

It becomes apparent that the institutional and situational factors focussed the attention towards National Health Service industrial relations at the local level. It would also seem certain, that this was an area of continual development-evolution.

An obvious question to pose is whether the National Health Service

industrial relations system showed signs of responding to these developments.

Issues arising from Whitleyism

Dimmock and Farnham (1975) commented:

> "At a time of extensive structural and managerial reorganisation within the National Health Service, it is a paradox that no apparent thought has been given to the need of modifying its collective bargaining machinery. The present form of Whitleyism has remained virtually unaltered since 1948, and the fact that it has received scant attention at a time of major change seems to reflect a belief that it has been, and will continue to be, relevant to the industrial relations needs of the Service."
>
> (1975).

A basic reason for this belief was that a conflict existed within the service between reconciling the need for administrative efficiency with that of equitable employee reward, given the priority accorded to patient care and to centralised budgetary control. In the event, greater emphasis has been placed on the requirements of firm managerial control and cost consciousness than on the efficiency and labour market sensitivity of the joint negotiating arrangements. The subject is hardly mentioned in the Management Arrangements for the Reorganised National Health Service (The Grey Book) - 1972, except as part of the Personnel specialists' function, expressed in conventional terms. Thus, while there has been in subsequent years, a positive approach to developments in managerial skills and techniques, there continued to be a resistance by both management and trade unions towards reform in collective bargaining structures. It will be

argued that consideration of evolution is necessary by identifying four main areas of weakness in the Whitley system.

1. Concentration at National Level

Dyson, (1975), identified a number of features which make National Health Service Whitleyism unique, and also cause problems. Unlike the local government Whitley Council system, almost the whole range of industrial relations decision making is concentrated at the national level, seemingly as remote from the National Health Service employee as possible.

This was done in part, because collective bargaining of any sort was considered inappropriate within a hospital - a special case of the framework offered by Donovan (1968). As cited previously, one consequence of this was the apparent failure to develop grievance or disciplinary procedures at local level, within reasonable time limits. The most progressive attempt was the Regional Appeals Committees which considered appeals against local interpretations of national agreements. There is broad similarity here with the local government Provincial Councils. Nevertheless, the National Health Service remained as an industry which tried to refuse recognition of any other kind of dispute, but one of interpretation.

The second consequence has also been referred to, the late development of local wage bargaining. The central intent of National Health Service Whitleyism was that industry wide agreements should regulate and control the actual earnings of employees within their ambit. In this way, the labour costs which are such a large element of total National Health Service expenditure, could be both monitored and contained along with

relativities and differentials. As has been seen, this centralisation ran counter to prevailing industrial relations trends. The moves towards local negotiation mainly served to reveal the absence of adequate machinery.

2. The Composition of the Staff Sides

The unique character of the central Whitley system highlighted a second problem area, the composition of the staff sides of the Councils. In 1948, because of the nature of employment in the newly formed service, trade unions and professional bodies were almost arbitrarily placed as equal partners on the staff sides, with no distinction as to rights and functions. Thus on the staff side of the Nurses and Midwives Council, the RCN, the RCM, COHSE, and NUPE sat down together as equals. In the early days, this does not seem to have caused insurmountable problems, but later developments brought underlying difficulties to the surface. The extension of bargaining downwards increased local union activity and inter-organisational confrontation occurred, especially over the search for membership. The Industrial Relations Act (1971) forced the professional bodies to consider their functions, and some, line the RCN, chose to adopt trade union functions and character. The result was a polarisation of trade unions and professional bodies. Dyson (1975) quotes as an example, the Nurses and Midwives Council of 22 seats, split into eleven trade union seats and eleven professional body seats. He also describes the conflict between the Society of Radiographers and ASTMS on the Professional and Technical (A) Council over the recommendations of the Halsbury Committee (1974). Staff side composition retained another feature adopted at the outset of the service in 1948 which reinforced the inability of the central institutions to respond to subsequent developments. Because of initial difficulties in resolving competing claims, large numbers of employee

organisations were recognised and given staff side status in the hope that they would improve the arrangements later - see Appendix 2(a) and 2(b). But the rule was also agreed that the staff sides should determine their own composition. In the natural course of events, there was subsequently little or no change or reduction in this respect. Dyson (1975) described the case of the Professional and Technical (B) Council as an example. Seven trade unions held staff side seats. ASTMS claimed a 50% representation in this group of staff, and there was evidence to support this. But USDAW was also on the staff side, yet had the smallest number of members in the National Health Service, due to an historical quirk. ASTMS resorted to precipitate strikes to demonstrate the unrepresentativeness of the allocation of staff side seats on the Professional and Technical (B) Council. The staff in hospitals may transfer to other alleigances, but this in itself could not alter staff side composition. This situation in addition to raising questions about the principles of representation, also encouraged dissatisfied groups to go outside the Whitley Council machinery. Dyson (1975) also cited the examples of the Laboratory Technicians in 1969/70 and the Works Officers in 1974.

A third feature of staff side composition also caused disruption. Multi-union representation encouraged inter-union competition (see Appendix 2 a). This was reinforced by the downward direction of labour relations activity. As unions perceived the need to organise more effectively at unit level, stewards were appointed, first amongst ancillary staffs, and then for nursing staff, whose principal initial function was to recruit and retain membership. With the increased levels of membership and local representation, competitive recruitment developed, and the controls exercised through the TUC's Bridlington agreement did not always prove

effective.

This was the case especially in the period following the 1971 Act when COHSE was outside the TUC and NUPE was quick to seize the opportunity to recruit nurses, especially in large general hospitals. There was consequently rivalry between COHSE and NUPE for nursing membership. This situation continued to add to the instability in National Health SErvice industrial relations because of the temptations to competitive militancy which it offered to the weaker union, whose positions did not require it to act responsibly. Dyson (1975) provides the example of the TGWU before the ancillary workers industrial action in the spring of 1973. The TGWU organised the majority of the first phase strikes in the Autumn of 1972, after the counter inflationary legislation. This union thus

> "stole the march over the other ancillary unions in recruitment terms by using a position of less responsibility."
>
> (Dyson, 1973)

NUPE responded by calling strikes at a more controlled level of action for counter publicity. The escalation of strike action resulted mainly from staff side competition and inter-union rivalry which aggravated other factors in the situation.

iii. Composition of the Management side and the role of the Treasury

A third problem area in the Whitley system centred on the management side; it should not be presumed that all of the difficulties were to be found on the staff side. "The Hospital" indicated that there were three distinct groupings on the management side, not necessarily having unitary objectives.

Local management representatives were primarily concerned to recruit and retain sufficient staff of adequate calibre to maintain them. They were the "pay agents" but the party directly concerned with the effect of the pay structures on organisation and efficiency.

The second party were the representatives of the DHSS, concerned with national policies and the overall efficiency of the service.

Thirdly, there was the Treasury, indirectly represented, which, though doubtless in favour of an efficient and effective health service, was mainly concerned with securing resources and the effect of pay agreements on rates of pay elsewhere. As stated:

> "It is unrealistic to devise schemes which depend on the assumption that this third party should simply be concerned to say yes..... The idea that the two sides should get down to negotiating without any interference from the Treasury does deserve to be called naive. There is surely a case for bringing the Treasury more closely into the Whitley negotiations".
>
> ("The Hospital" - editorial 1971)

The presence of the Treasury as the governments agent in managing the economy, having regard to the tax payers' interests, and exercising restraint on the spending Departments, was clearly the key issue on the managment side. It highlighted the dual position of the government as the manager of the economy and as an employer. An agreement made by the Whitley Council could be vetoed by the Secretary of State. Cumming (1971) cites the case of the 1957 award to the Administrative and Clerical Whitley Council.

iv. Fragmentation

Underlying these problem areas in a fourth, the fragmentation of the central negotiating machinery into autonomous bargaining units. This splintering of staff was another unique aspect of the National Health Service. Ultimately nine Functional Councils were established, who undertook the major part of negotiation, although there was also a General Council which laid down conditions of Service common to all employees, and formulated policy on such matters as race relations. Theoretically this sectionalised negotiating structure would be responsive to the needs of particular work groups in a large multi - occupational work force. In fact, it produced a great complexity of agreements which have often proved to inflexible especially in terms of recruitment in some of the labour markets to which they relate. The inclusion of the Ambulancemen's Council, following 1974, added to the complexity, since it has a different, non-statutory, basis. Growing union activity had obvious consequences. In 1974, the General Secretary of NUPE (Mr. Alan Fisher) publicly emphasised the growing importance of differentials between groups of staff, and the fact that the awards and decisions made in one Council of the Whitley system now affected the negotiations in others. It could be argued that the back-dated Civil Service linkage obtained by the Administrative and Clerical staff in spring 1974 undoubtedly influenced the militancy of the nurses. Mr. Fisher called for a comprehensive review of wage awards and conditions of service : there were still too many variances between Councils. He quoted normal hours of work as an example of this.

A second consequence of growing union activity was an increase in the volume of business which the fragmented system has to handle - a self fulfilling prophesy.

Dyson indicated that claims for pay awards increased from one every five years or so in the 1950's, to more often that not, more than one a year in the rapidly inflationary economy of 1974. He raised the question:

> "is there a need for full time specialists to handle this increase and resulting increase in complexity. The details of one agreement are scarcely worked out and implemented before the next claim is placed on the table. So, at a time when workers expectations are being heightened, the central machinery is showing a tendency to slow down. Furthermore, much of the business it cannot deal with is being pushed back down for local negotiations to make what they can of".

Commenting on the Halsbury Report (1974) Dyson stated:

> "The money was paid in the end and backdated, but done in a way that eroded (to no purpose) the loyalty and support of staff. The fragmented and cumbersome bargaining system is largely responsible for this, and some system for linking or at least for synchronising the movement of pay scales must surely be priority for reform".

Two further comments on fragmentation must be made, it offered advantages to the management side, especially to the parties concerned to find resources at the DHSS. While the staff sides could normally appreciate part of the whole, the DHSS was operating strategically at a macrolevel. It was concerned to maintain an overall balance between the resources expended on wages and salaries, and staff costs. It could therefore effect virement between Councils, using in particular the device of the "interim award" to help to establish balance.

Fragmentation conversely put a premium on militancy, to ensure that the

staff interests concerned emerged well from the "balancing process". Dysan considered that as the militancy developed, the advantage held by the DHSS because of fragmentation would be lost, eventually resulting in the reform of the Whitley System.

The final point on Fragmentation relates to the medical profession. Doctors refused to join the Whitley System since it began, although some sub-committees of the appropriate Council did meet. They negotiated directly with the DHSS directly through the Pay Review Body. As such, they were a constant reminder of what strength and unity of purpose could achieve. The BMA has been the dominant representative professional body, and was ironically referred to as "the best trade union in Britain", (Fisher 1974). Paradoxically as other groups of staff and unions gathered strength and unity, it could be observed that the former dominance of the BMA was challenged by other doctors' organisations. There was clear evidence that the Hospital Consultants' and Specialists' Association made great progress in recruiting from the BMA. After a struggle which was referred to the Industrial Court, the BMA recognised the HCSA and tried to reform a united front. The Junior Hospital Doctors' Association also gained many members from the BMA, although its membership was by definition, highly volatile. The Medical Practitioners' Union also claimed a rapidly growing rate of recruitment. It is interesting to note that both the JHDA and the MPU are part of ASTMS, which gained success from overtly militant policies.

This spread of unions within the medical profession symbolised a fragmentation of interests among doctors which became more acute than hitherto. The first manifestations of the implications of this was the almost total isolation of hospital consultants during the struggle with the

DHSS over the right to treat private patients on National Health Service premises. The DHSS effectively separated consultants from the junior hospital doctors and the general practitioners, and certainly contributed to the eventual outcome. This indication of "weakness" in the profession resulted in doctors no longer securing control the initiative, which was taken by ancillary workers whose overt militancy grew following the "strike threshold" of 1973.

v. Reform of Whitley

This review has identified a list of weaknesses in the Whitley System : rigidity, overcentralisation, problems arising from membership and fragmentation of the Councils etc. Areas for reform were relatively to easy to locate and were made the subject of McCarthy's report, in 1976 - "Making Whitley work".

It may be argued that the terms of reference under which McCarthy was commissioned to investigate were such that the ensuing report was quite predictable. The remit limited McCarthy to repair rather than reform, and it had to rely on ex parte evidence from management and staff representatives, rather than on other methods.

McCarthy's recommendations had two main themes, firstly concerning representation on the committees, and secondly proposing the formation of locally based committees. The aim was towards decentralisation except for the vital issue of pay bargaining.

Another area of consideration was the resolution of the problems caused by fragmentation : disputes between professional bodies and unions, between autonomous groups of staffs and the potential difficulties arising from the

apparent premium on militancy resulting from the balancing role of the DHSS. Resolution of some of these problems depended on the views of the unions.

When the initial DHSS policy contained in the Grey Book (1972) is considered:

> "Once agreement has been reached at national level on pay and conditions of service, steps must continue to be taken to see that what has been agreed is implemented locally".

a) The DHSS will issue circulars setting out the terms of the agreement and it will be the responsibility of Authorities and their managers to see that they are implemented.

b) The DHSS will continue to authorise local variations from national agreements, at least the period immediately following NHS reorganisation. Longer term, however, once specialist personnel departments are effectively established at RHA's, authority to agree local variations may in some cases be delegated to RHA's by the DHSS within clearly established guidelines".

It was difficult to assess where the stimulus for structural change would emerge.

Participation

The trend towards local bargaining had wider implications than the ability of the Whitley System to cope. It raised the question of participation by employees. Within the context of the National Health Service, Gourlay considered the problem on "exchange theory". The basic postulate of this

theory is:

> "exchange consists in the voluntary actions of individuals that are motivated by the returns they are expected to bring, and do in fact bring, from others".
>
> (1975)

The two types of exchange under consideration are social exchange and economic exchange. Gourlay (1975) argues that there was an increasing tendency with the National Health Service towards viewing work and remuneration as an economic exchange; whereas, in the past it could be argued that they were viewed more on a social exchange with the employee having more discretion as to how he would carry out his work. Exchange theory indicated that the main consequence of an economic exchange was a diminution in the trust levels between the contracting parties. Because it involves bargaining over terms, there was a requirement to make the terms as specific and explicit as possible. This is unlike social exchange, which, because the obligations are diffuse and unspecified, requires trusting behaviour and which accepts that obligations will be discharged. From a work point of view, this lack of trust was likely to engender closer supervision and the installation of controls for monitoring work. Social psychologists point to a subsequently low commitment to the job on the part of the employee.

Gourlay (1975) saw this "gloomy scenario" as almost inevitable, but offered:

"let us increase the amount of participation for employees in the decision making processes of the organisation. By this we show we trust them, give them responsibility and demonstrate that we are not going to nail them down".

(1975)

As with many concepts evolving from judgements which are value laden, participation is not easy to implement. Gourlay suggested a number of means of encouraging indirect participation which were perhaps less than satisfactory. He suggested that the trend towards local productivity bargaining and away from national collective bargaining allowed employees more control over decisions in relation to planning and labour utilisation, and in some cases direct participation in the form of job enrichment. Puffit (1975) argued that productivity bargaining placed the initiative in the bargaining situation with the employees. The inference from the 1968 NBPI report calling for fully work studied schemes, would seem to deny much element of participation. Gourlay indicated doubts about the two potential forms of indirect participation which he described, in that research had demonstrated that joint consultation had proved largely ineffective in ensuring that employees have a voice in the management of an enterprise. Miles and Smith (1969) survey indicated that the main reason for failure was the indifference shown by senior management. The problems described by Fisher and Drain (1975) however were;-

"the limited nature of the subjects which can be discussed, and the lack of management response when recommendations - and they can only be recommendations - are made by a JCC".

There was similar evidence that worker representation on management boards

would not achieve all that it appeared to in Germany, Scandinavia and Yugoslavia. Puffit (1975) indicated the intrinsic contradiction in being a worker representative and a member of the management team at the same time, and also to the differences in national culture which would impede the transfer of the concept to Great Britain.

The Legislative Framework

The period of 1960-1974 was one interest in terms of industrial relations legislation. Discussion began with the Donovan Report (1968), whose analysis of the "two systems" has been outlined. The publication of the Report in 1968 established the climate for a reconsideration of the relationships between low, government, management and organised labour. Until this point, the system had been most usually characterised as a voluntary system, unregulated by low. As Kahn-Freund described:

> "There is perhaps no major country in the world in which the law has played a less significant role in the shaping of (industrial) relations than in Great Britain, and in which today the law and the legal profession have less to do with labour relations".
>
> (1972)

Clegg described the government role as one of holding the balance between employer and employees, using the law only to offset the most blatant inequity. He pointed out that although there is a substantial body of statutory labour law:-

> "The point is that the great bulk of industrial relations lies outside the scope of these statutes".
>
> (1970)

Since 1968 there has been a vigorous debate, centred on the degree of legislation which is appropriate for the improvement of labour relations. Armstrong used the description

"straitjacket or framework".

(1973)

to characterise the poles of the argument. Concensus in the debate cannot be reached, hindered by the exigencies of party political debate and short term political fortune as exemplified by the loss of the industry Relations Bill following the defeat of the Labour Government in 1970. Armstrong traced the development of what he called the "border line" from the Conservative publication "A Giant's Strength" in 1958, through a "Fair Deal at Work", published in 1968, and in the "Industrial Relations Bill Consultative document":-

> "In all the features of our voluntary system - association, organisation, recognition, bargaining, agreement, disagreement - the Industrial Relations Act intervenes, or makes provision for potential intervention ..... Whatever its precise practical effects, as a piece of legislation the Act does represent a massive intervention by the state into the procedural aspects of industrial relations".
>
> (1973)

After repeated controversy, the 1971 Act was repeated following the Conservative Government's defeat in 1974. The period following the change in Government resulted in what Armstrong identified as "a softer line" embodied in the Trade Union and Labour Relations Act of 1974, and the Trade Union (Amendment(1976)), Employment Protection (1975) and Consolidation (1978) Acts.

Implications for Management

The early development of industrial relations affected National Health Service management at two levels. Conceptually, it may be discussed in terms of management style. An appropriate style must reflect the regard for the individual. This emerged from the trend towards local bargaining, the trend towards employee participation, the implementation of employee - orientated legislation. As Gourlay described:-

> "In terms of a management philosophy, the assumptions about the nature of man contained in McGregor's Theory are expoused. There is a genuine belief that people do want responsibility, that they can exercise self control in the performance of their job, that they are not inherently lazy.....
>
> The managers no longer predominantly see their job as controlling and coercing, but much more a process of facilitation and help to their subordinates. We move to a management style variously described as 9.9, system 4, participative etc. Jobs are designed for people to develop their talents and to grow psychologically through the exercise of their responsibility in fulfilling the diffuse obligations arising out of the social exchange".
>
> (1975)

This style is sometimes proposed as an activity, good in itself, sometimes as a means of maintaining of increasing productivity, sometimes as both. In each case, what it does is advance the interests of the employee as a legitimate objective of the organisation. The consequence may be, however, that it is not possible to optimise the pursuit of all the organisation's

objectives, and so some may lag behind if employee interests are given top priority. In the case of the National Health Service, it could be the interests of the patients which would suffer.

At the second level of impact, National Health Service managers had to consider their responsibilities for sound industrial relations with more seriousness and skill than had been evident in the past. As partners in the process with employees and their unions, with government and the law the process was urgent but delicate. Four requirments predominated, firstlly to more towards a more adequate machinery for bargaining. This indicated a need for modifiation and reform of the Whitley System, but despite this, to agree suitable procedures for grievance and discipline. Secondly, there was the need to develop skills for bargaining at local level. Despite the acute need for this development, Laurence noted:

> "Unfortunately this lack of industrial relations expertise appears to persist right up the management tree. The turnover in career civil servants, who staff the management side secretariat at Whitley level is such that, if they have the propensity to develop negotiating experience, they have not the time".
>
> (1973)

The unions however could draw on experience gained form dealing with other organisations, and were training their negotiators with more energy than management.

Thirdly, was the need to appreciate and implement the relevant parts of statutory provisions. This involved considerable flexibility and awareness as the body of law was increasing and changing at such a rapid rate.

Perhaps the most pertinent example was the law relating to unfair dismissal. This developed in the 1971 Industrial Relations Act and strengthened in the 1974 Trade Union and Labour Relations Act. Referring to the newly introduced concept of 'constructive dismissal' Edwards commented:

> "Health Service Managers are worried that the popular approach of persuading an employee to resign may now be challenged".
>
> (1975)

Management procedures were therefore questionable, and special consideration had to be given to the question of who had the power to dismiss. Berridge (1975) argued that this right would not be exercised below Sector Administrator level. Agreement also needed to be made concerning sound and efficient disciplinary and grievance procedures. Time limits for making complaints against unfair dismissal were extended to three months, and industrial tribunals had discretion to hear complaints made 'out of time', but this provision contained an implied requirement for up-to-date and accurate personnel records. This type of attention to legislative requirement extended over the whole body of labour law.

The fourth requirement focussed on the understanding of the role of management in industrial relations. Much of this has been implied in the discussion of local bargaining, Whitleyism, participation and legislation.

The need was recognised to consider the employment of Industrial Relations Specialists.

The development of the new role of Industrial Relations Specialist in the National Health Service was not encouraging. Donovan had offered somwhat

disparaging views:-

> "Many of the older generation of personnel managers see themselves simply as professional negotiators. Even if a personnel manager has the ability to devise an effective personnel policy, the director responsible for personnel (if there is one) or the board as a whole, may not want to listen to him. Many firms have acquired disorderly pay structures and unco-ordinated personnel practices before they appointed a personnel manager, and the burden of dealing with disputes and problems as they arise has absorbed his whole time and energy".
>
> (1968)

Secondly Donovan recommended that the responsibility for reviewing industrial relations should be located totally with the boards of companies. Little was said about a potential contribution from the specialist. This rather gloomy view of the industrial relations specialists role was echoed when considered in relation to the National Health Service. Personnel management as a specialism itself was of recent growth. The DHSS circular HM(72)65 issued in September 1972 was the first recognition of a comprehensive function. Although the document was largely devoted to putting the case for training as a specialised part of the Personnel function, one sentence covered industrial relations, and that conveyed little urgency or awareness of the magnitude of the problem:-

> "The Industrial Relations Code has highlighted particular aspects, (of consultation; organisation; grievance and disciplinary procedure) and illustrates how important it is that the personnel function is performed sensitively and skilfully by line managers and by the specialist personnel staff who support them".

(1972)

The same sentiments were evident in the Grey Book, although it did recognise personnel management as generally a major management process, along with planning, monitoring and controlling. But in detail, it highlighted selecting and appointing staff, developing managers in the National Health Service, and controlling estabishments and staffing costs as the major tasks. As was described in the section on the reform of Whitley, national agreements continued to be the norm. Considering the model role specification for the Area Personnel Officer, of 21 items of responsibility, 4 impinged upon industrial relations.

> "4.2 Coordinates distribution of Whitley Council circulars and RHA personnel policy statements and, where action is required, brings this to the attention of the managers concerned.
>
> 4.4 Provides advice on implementation of productivity schemes and keeps in touch with national developments in this field, e.g., identifies successful schemes so that managers can visit the units involved to evaluate them for themselves.
>
> 4.5 Identifies the local implications of any new legislation affecting industrial relations and advises managers on steps to take e.g. to meet the requirements of the Industrial Relations Act.
>
> 5.2 Develops consultative arrangements including those for staff wishing to bring matters to the attention of senior managers, and advises AHA and District staff on steps to take in the event of disputes with staff."
>
> (1972)

This prototype was modified by Area Personnel Officers on appointment, but limitations were imposed by national agreement, and lack of staff skilled in the knowledge of industrial relations. However, the pressures continued to move towards the decentralisation of bargaining.

Anthony and Crichton (1969) offered two possible frames of reference for the specialist - firstly

> "that there are no necessary and deep divisions of interest between sections of the industrial community".

> Secondly

> "The alternative to this unitary frame of reference is that divergencies of interest are a real and inescapable accompaniment of organised work processes".

The first implies that separate representation of employee interests is uneccessary, because management, and especially the personnel specialist, do this adequately. The second implies that it is essential for the disparate interests to be independently represented. This introduction indicates that in the National Health Service only the second frame of reference can be held. This removes some of the "ambivalence of attitude" which Anthony and Crichton saw in the specialists' role. There is no question of the specialist acting as a representative or "honest broker" of the work people's interests. He is, as Forman (1964) recognised

> "An integral part of management with emphasis on achieving optimum results from the human resources of the business".

In the particular National Health Service context, the industrial relations specialist had a potentially vital role as part of the management team. Lupton (1964) described the Personnel Manager as" the technologist of the behavioural sciences" and as such had a latent potential towards reform.

THE EVOLUTIONARY PROCESS 1974 - 1980

GENERAL TRENDS

1974 1980

The subsequent development of industrial relations in the National Health Service may be divided into three main phases. From the end of 1972 until the begining of 1976 there were three years dominated by national disputes about pay (see appendix 3). These had been foreshadowed in the laboratory technicians' dispute of 1968-69 and the electricians dispute of 1970, but the intensity increased after 1972.

As Edwards' states:

> "Despite clear warnings, it was not until the mid 1970's that management in the National Health Service began to take industrial relations seriously".
>
> (1979)

Some disputes arose from incomes policy, others were unsettled issues of grading arising from the reorganisation of the National Health Service in 1974. The disputes offered elements of novelty in terms of readiness for local industrial action, but there was also much that was traditional. The disputes over hopital doctors pay re-echoed the dispute over the Kindersley report (1970) concerning general practitioners pay. The nurses' pay dispute was preceded by the argument with Enoch Powell and by the Rcn's "raise the roof" campaign of 1970. The most important new feature however, was that the disputes contributed to a permanent increase in membership and activity of trade unions locally. This was consolidated in the second phase of "the troubles" from 1976-1977 (see appendix 3), which were principally local disputes following reorganisation in 1974.

From 1978 until 1980 a new phase of nationally organised disputes developed, concurrent with continuing local disputes.

The first major national dispute was the ancillary workers' strike in 1972-73. The immediate precipitating cause was an anomaly in the operating incomes policy. The pay of National Health Service ancillary staff had traditionally been linked after a few weeks delay to settlements for local government staff. Local government settled before the introduction of the statutory incomes policy, and the traditional link was broken. NUPE was placed under great pressure not only from members, but also the other unions representing the ancillary staff - GMWU, TGWU and COHSE. The pressure of unofficial action, particularly from TGWU led to the first demonstration of concerted action. An official one day strike on 17th December, 1972 was followed by a ballot on further action. The ballot produced a majority for a national strike, but the unions preferred selective strikes, an overtime ban, and withdrawal of co-operation. There was little detailed guidance however from national union headquarters, and much was left to the initiative of local shop stewards. They had the responsibility of negotiating both types of action, and about types of emergency cover to be provided. As Dyson (1974) reported on the dispute in Leeds

> "What made the crisis worse, where the strikes occurred, was that often there was no committee of stewards with whom to negotiate. The machinery had to be set up first and all the time things like laundry stocks were going down..... The longer these negotiations dragged on, the weaker management's position became, whilst the stewards grew more confident".

The stoppages did not achieve their main objective, but did result in both increased membership and new determination.

The next national dispute also arose from incomes policy but was more intense because of interunion rivalry. This was the conflict over nurses' pay in 1974. Nurses had received a large award in 1970, but by 1974 the diffential was widening. Rivalry between unions had been engendered following the introduction of the Industrial Relations Act 1971. This prompted the Rcn to adopt a more active local role, including the appointment of stewards. Also, COHSE left the TUC, a decision which protected its membership from the Rcn but which lost its protection from the Bridlington agreement, and enabled NUPE to openly "poach" members. The nurses pay dispute therefore, provided the opportunity for COHSE to re-establish itself, and for the Rcn to consolidate its new role. The government, in response, established a special committee of enquiry whose recommendations proved generous (Halsbury 1974). The absence of local action was the major reason for the longer term effects of the dispute - greater membership and activity.

Medical staff were the next group involved in industrial action. The Consultants began to work to rule in 1975, in protest about the breakdown of negotiations over new contracts. Negotiations had commenced in 1972.

Junior hospital doctors then took industrial action, considering that the new system of payment for overtime would work to the detriment of some staff. The new attitude was developing, and as the BMA annual conference was reminded:-

> "We are in a jungle gentlemen and unless we fight like the others we will go down".
>
> (1974)

The atmosphere became confused when the issue of the consultants contract became temporary linked to that of the future of private practice, resulting from a local union action by other staff against private practice. The consultants, it may be argued, had the legitimate grievance about the protracted negotiations concerning their contracts. The junior hospital doctors dispute of 1975 however, was more dubious.

The junior hospital doctors were in dispute against a settlement whcih they had been party to - but on points of interpretation which should, procedurally, been referred to the Review body on Doctors' and Dentists' pay.

In both cases, competition both for negotiating rights and for membership had intensified the dispute. The BMA was experiencing a challenge on its sole negotiating rights for consultants from the Hospital Consultants and Specialists Association (HCSA). The greatest effects of this rivalry were experienced in the junior doctors' dispute. At the end of 1975, it was the acute competition between the Junior Hospital Doctors Association (JHDA) and the BMA which precipitated industial action. Although public discussion focussed on the novelty of industrial action by doctors, the medical staff proved cynical.

> "in twenty years of negotiation with the Department of Health, the fundamental problems of junior doctors.....figure little if at all".
>
> (Gordon and Iliffe 1975)

The three major groups of disputes affecting ancillary staff, nurses, and doctors were the largest. There were some associated "relativity" claims for large pay increases by radiographers and other staff.

There were also a number of claims for regrading arising from the reorganisation of 1974. The most important affected catering officers, works officers and ambulancemen.

The period 1972 until 1980 was dominated by a number of national disputes. Management were often preoccupied with the problems caused by reorganisation and proved reactive to events and initiatives from unions at local level. There was an intensification of co-ordinated action between 1976-1980. On the stafff side there were more shop stewards, more competition for union membership, and increased scope arising from new labour legislation, particularly on disciplinary matters. On the management side, there was a greater willingness to take initiatives, even though these were often felt to be confused and hampered, because of the management structure. Most Health Authorities were negotiating local disciplinary and grievance procedures. By 1974 only 10% of Health Authorities had agreed local procedures for grievance and disciplinary matters : by 1978, 90% had negotiated them (Fewtrell 1980).

The activities of personnel staff were seen to be more overt - negotiating these procedural documents, introducing joint consultative machinery, and productivity schemes. Activity on the more discretionary areas of industrial relations was not so apparent. The Health and Safety Executive in its first report commented:-

> "in a general assessment numerous examples of poor environmental conditions were found throughout the hospitals, involving extremes of temperature and/or inadequate ventilation. It is significant that these problems were not confined to older (Victorian or pre-war) buildings but were also found in modern units".
>
> (1978)

In many authorities, little money was spent on the improvements of working conditions or staff residences. Joint staff consultative machinery was found to be difficult to operate, because of the potentially large numbers of staff representational groups who could claim seats.

Some authorities, initiated by Newcastle, negotiated agreements on facilities and time off for shop stewards. It was more unusual, but evidently initiated by Northampton, to begin a move towards the negotiation of union membership agreements. In view of the interunion rivalry which existed, union membership agreements remained more unusual than "spheres of influence" agreements.

The main change during this period however, was the underlying change in relationships and attitudes and the attempt to accommodate them in the new procedures. These changes in activity affected many more staff, directly and indirectly; but as public events, the disputes commanded attention accentuated by widespread press reporting. Local disputes before 1976 were principally about disciplinary matters - a strike at Morriston Hospital Swansea in June 1975 by 400 ancillary staff in protest action against a shop steward, and in December 1975 industrial action was threatened in Liverpool unless disciplinary action against a shop steward was withdrawn. From 1976 onwards, local disputes became much more common until the period of 1978-80.

The dispute of 1979 became inevitable following the breakdown of Whitley Council negotiations in December 1978, for acceptable pay awards for Ambulance and Ancillary staff. The 'final offer' of a 5% increase was rejected by staff and notice was given of national strike action for all staff to commence on January 22nd 1979.

The dispute was traumatic for several reasons, not only its durations, but the juxtaposition of the major parties involved, i.e.

i) The Secretary of State and the DHSS

ii) The managers

iii) Trade unions and Professional organisations

iv) Health Authority members

The Secretary of State and the DHSS

The Secretary of State inevitably sought to centralise policy formulation concerning the dispute, and prior to the action notified all authorities to:-

> "await departmental guidance before suspending staff, withholding pay from those who were taking industrial action, or laying off staff..."
>
> (DHSS 15-1-79)

but on 24th January advised:

> "local management should begin to exercise its normal discretion in responding to industrial action ..."
>
> (DHSS 24-1-79)

This pattern of discretion being granted then witheld, then granted again was repeated for the duration of the dispute. The DHSS was inconsistent in its advice concerning the use of volunteers to maintain services, advising on 14th March:

> "... authorities are free to seek help from members of the public as the need arises ..."
>
> (DHSS 14-3-79)

and yet only two days later, stated:

" ... there is a real danger that using NHS Ambulances with volunteers will exacerbate the dispute locally, and could lead to sympathetic action by other NHS staff, and cause industrial action in other areas ...."

(DHSS 16-3-79)

The DHSS had, in 1978 issued a document to the Regional Personnel Officers (Appendix 4) which sought to standardise the procedure:

"establish an information system for monitoring the climate of industrial relations in the NHS ... "

(DHSS July 1978)

This was the basis of contact between the DHSS and Health Authorities during the dispute. However, it became apparent that communications did not reflect the true situation at local level. Confusion existed between definition of emergency services, minimum services, and essential services.

The dispute lasted for seven weeks, resulting in a pay award of 9%, plus £1 anticipated from the outcome of the Clegg compatability study, which reported in August 1979.

ii) The managers

The managers, at unit level had been advised by District and Area managers to initiate discussions with local shop stewards in December 1978, to assess the possible effects of action. The majority of managers prepared minimum acceptable levels of staffing for units, and commenced the preparation of contingency plans.

At District and Area level, the personnel departments predominantly planned the communications system which could relate relevant information during ensuing action. Negotiating teams were established (drawn from functional

administrators in Personnel, Nursing etc.) and negotiations were opened with full time officers of the Trade Unions involved, to establish guidelines, and points of contact.

Area and Regionally based officers were responsible for reporting regularly to the DHSS, on the effects of the dispute.

There is evidence that the reports to the DHSS became progressively and deliberately more inaccurate during the dispute, relfecting maangers growing cynicism about the ability of the DHSS to cope with the situation, and the view that the dispute was being used politically without concern for the local effects.

iii) Trade Unions and Professional Organisations

The Trade Unions, for the first time in the National Health Service had successfully co-ordinated action towards a specific objective, and had removed large numbers of staff for the 'day of action'. They maintained the co-ordination until interunion rivalry became the focus of attention, towards the end of the dispute. This was caused by pressure from the membership of the unions, some of whom had been identified as 'key' staff and had been called to strike repeatedly. In this way, the effect was maximised, yet the financial implications restricted. Throughout the dispute, an overtime ban was operational. Members of the affected groups began to leave the most militant unions, to later join those whose stance had been less expensive for members in pecuniary terms.

It was also evident that strain developed between the full time union officers and their shop stewards, as the dispute became protracted. The presence of picket lines at major key units did not improve inter and intra

union relationships, as it was viewed as an example of distrust.

iv) Health Authority Members

The Health Authority members were the local lay body to whom the Chief Administrative staff were responsible for the provision of service. In September 1973, the DHSS issued advice (see Appendix 5) relating to the possible relationship that members could achieve with managers concerning personnel management.

Whilst the Health Authority members were informed on a regular basis of the effects of the dispute, an emergent trend was of political interest related to the origins of the members. Members were nominated from several sources, the dominant nominating body being the Local Authority. Local councillors who also were Health Authority members, often found great difficulty in resolving their divergent interests.

Indeed, the problem of identity was not solely the prerogative of Health Authority members. Many local managers had great sympathy with the principle, if not the practice of the dispute.

Causal factors of change

There is evidence that the activity between 1974 and 1980 was the breakdown of the old "colonial" system, most totally at local level; at national level the institutional structure survived, despite changed attitudes.

Dunlop, (1959), described the 'system' of industrial relations - centralised on the rules, procedures and agreements which govern conduct - and that system was now under severe stress. Technological change had been rapid, occupations had become more complex and varied, and technology had

increased the bargaining power of various groups. The financial position of the service changed, with much greater pressure to cut costs, and power shifts in society affected attitudes within the National Health Service. Attitudinal changes were also evident -

> "the internal culture of dedication and vocation has changed. The world of the National Health Service has become rather less closed."
>
> Berridge 1976

Superimposed upon all the sociological changes was the effect of reorganisation, restrictions on public spending and the changes in labour legislation. The basic problem, as indicated earlier, was the lack of structures to cope with the cumulative effects experienced.

The National Health Service was not unique, indeed parallels with other public sector industries may be drawn. The effect of incomes policy created persistent tension about pay in the public sector. There were some special features - the assertive policies adopted by some unions, also the continuing difficulty over resolving routine issues and controversies - indicating the lack of an effective local system. The national disputes over pay were not as unexpected as the continuing local pressures. There was also the growing awareness about the perceived status of staff. (Saunders 1981).

The National Health Service must be considered unusual in the extent to which people with very different levels of pay, training and status are brought together so closely, and in which basic inequalities are so visible.

Responses

Within the National Health Service, the response of management was principally of two kinds. There was the formal response through official DHSS circulars and the McCarthy inquiry (1976). The DHSS circular HRC(73)37 indicated a required need to strengthen personnel services. The District Personnel Officer was charged to:

> "give advice and services to line managers and staff in the district on a number of topics."

The eight item is

> "industrial relations including joint consultation."

The second area of policy was towards consideration of decentralisation of Whitley Council machinery, following the McCarthy report (1976).

More important than the formal initiatives was the response in some areas and districts towards local negotiation and agreements. As described by Armour and Torrington:

> "managers need to base their working relationships and arrangements with employees on a series of agreements containing elements contributed by both parties and having strong moral authority over the parties as a result of voluntary negotiated consent."
>
> (1976)

Local management made several responses depending upon the sequence of stimulus. Agreements were negotiated, most commonly on discipline and grievance issues, and in few cases, on facilities - with shop stewards. Generally too, personnel departments were strengthened, and senior managers were compelled to spend more time on industrial realtions (Stewart 1976). The point within the service at which these responses occurred was varied - unit, sector, district, area, region, all potentially involved. The

response was also confused by the strengthening of the role of functional management, again at several levels in the organisation.

ACAS identified several defects, in its evidence to the Royal Commission:

> "there are three fundamentally weak links in the organisation,
>
> i) Area/District relationship
>
> ii) The industrial relations role of District management teams
>
> iii) The industrial relations role of line managers "
>
> (1978)

and concluded:

> "we consider that our contribution to good industrial relations in the National Health Service would be more productive if at least some of our resources were allocated to assisting the DHSS and the Regional Health Authorities to take the lead in establishing central guidelines and back up for a more comprehensive and co-ordinated industrial relations policy. The responsibility for this must lie with the DHSS and the RHA's."
>
> (1978)

The comments of ACAS were directed at the National Health Service generally. By mid 1979 it was apparent that districts and areas had fallen into two distinct groups. The large majority had made some adjustments to change, the small minority who had not, were incident prone. This group was mainly concentrated around central London.

To the usual forces of change, such as new labour legislation and reorganisation was a newly manifested intensity of bad feeling and lack of mutual respect between stewards and managers.

Management Attitudes

The reorganisation of April 1974 was particularly unsettling to managers for two specific reasons. Firstly the slowness with which new appointments were made, and secondly the amount of movement between jobs. Many senior managers were appointed to new districts, and there was considerable promotional movement of other staff, resulting in key positions being filled by relatively inexperienced officers. Organisational relationships were therefore extremely delicate during the period 1974-1976.

However, by the summer of 1974, the nurses and radiographers were involved in official dispute and the ancillary staff representatives were pressing the issue of private treatment on National Health Service premises. In January 1975, the Consultants took industrial action - feeling frustration about their contracts, but also concerned that the new management structure was not defending their clinical freedom concerning admission policies. The action at local level by Consultants, could be perceived as a watershed in the National Health Service. Managers of the service perceived consultants as a legitimate part of the management structure - but now local pressure was being exerted to effect national agreements - what could the manager do? The action lasted for three months - but the effects were felt for many years.

Once consultants and junior doctors had been perceived as putting their own interests before that of the patients, other staff groups had less hesitation. The claim that 'the patient comes first' had been ignored, leaving local managers with feelings of futility and helplessness. The trade unions realised this and sought to effect local variations of national agreements, and even to instigate negotiations over matters which

were not the subject of national agreement.

Many health authorities conceded to junior doctors and radiographers, and entered rather spurious productivity deals with ancillary staff to ensure guaranteed levels of take home pay.

Whilst it is possible to be critical in hindsight, the needed guidance from the DHSS was not forthcoming. One response received during this period from the DHSS:

> "if lives are at stake, do whatever you consider to be the best in all the circumstances."
>
> (1975 - DHSS)

exemplified the problem.

During this period the first evidence began to emerge of the unco-ordinated approach to the problems of industrial relations by management. Area managers were negotiating separately with local trade union officers, with little evidence of co-ordination with managers from adjoining Areas. Consequently, 'leap-frogging' claims became common. This was almost inevitable, in that the 1974 reorganisation had created new health authorities from amalgamations of old ones, each of which had its own personnel policies. Even within the national framework, significant variation existed in the interpretation of DHSS circulars prior to reorganisation, particularly about grading.

These problems are perhaps best exemplified by the experience of the Ambulance Service. On April 1st, 1974, many of the new health authorities became responsible for the management of a service with staff drawn from several former authorities. The staff were on different bonus schemes, had widely varying rates of take home pay, and conditions of service. The

ambulance staff sought to remedy the variations by 'levelling-up'. In this, they proved reasonably successful, but set precedents which management found very difficult to control.

By 1975 several health authorities, particularly Liverpool, Leeds, Manchester, and Sheffield openly considered reducing the numbers of Districts contained within each Area. By the end of 1976 therefore, the Administrators, and more particularly the personnel officers who had been attempting to resolve the difficulties of service maintenance perceived threats from all sections. Even the Secretary of State, Mrs. Castle, commented publicly:

"we never designed this bureaucracy."

(1976)

The Whitley Council Structure

Despite minor modifications to the Whitley Council structure subsequent to the publication of the McCarthy report (1976) the system still failed to function adequately. These weaknesses could be identified as:

i) reconciliation of national agreements with local flexibility

ii) inter group differentials

iii) identifying the authority of managers and ensuring their co-ordination.

ii) National Agreements and local flexibility

The major failings of the Whitley Council are described in Chapter I, but these weaknesses identified in the pre-1974 structure became more acute during the period 1974-1980.

The concensus of managers was to maintain the principle of a national pay structure. It had attractions for both staff and managers in the maintenance of equity. It may be argued that national agreements limited the scope of local bargaining and therefore conflict. They restricted the possibility of leap-frogging claims and competition between employers which could distort differentials.

Lord McCarthy recognised this problem, and suggested the development of more flexible national agreements, which would retain the benefits of the national structure but could permit local variations. The problem viewed by managers was the selection of issues where flexibility would be appropriate, without damaging the structure of national agreements.

One of the first examples of a flexible national agreement was that relating to the allocation of two extra statutory holidays. The decision as to which days would be selected was left to the discretion of local managers. The staff were consulted, and could often not decide which days should be taken, and much local conflict existed between local trade union officials, as well as between management and staff. In many cases, the ambulance staff selected days different from hospital staff - resulting in the effective loss of four days, not two. Managers formally requested that this local flexibility be removed, and the two days nominated nationally, or added to annual leave entitlement.

Internal differentials also became an increasing source of conflict and militancy. This was initially felt following successive incomes policies, but was exacerbated by the failings of the Whitley Council machinery. Little effort was made to co-ordinate agreements made by the various functional councils, which operated as independent bargaining units, with

the inevitable results. Productivity bargaining for ancillary staff grossly distorted differentials with supervisory staff, whose salaries were negotiated in separate councils.

The structure of the management side representation also caused further concern. Following the McCarthy recommendations, the staff side membership was modified on the Whitley Councils. The Ancillary Staffs Council in 1978 wase reconstituted to comprise:

Chairman of Health Authorities	3
Members of Area Health Authorities	7
Regional Administrators	2
Area Administrators	2
District Administrator	1
Area Works Officer	1
Area Treasurers	2
Civil Service Officials	5
	23

It is apparent that lay members of the health authorities became the largest single group, and no personnel officers were involved. The processes of negotiation are undertaken, on all functional councils, by civil servants, usually with no experience of National Health Service management. Indeed few have any specialist training in personnel management or industrial relations.

Line and function relationships

The third area of concern identified by ACAS, was that of managerial authority and co-ordination. At the local level this became an area of major concern. The local unit manager frequently was given the

responsibility to manage staff for whom he had no responsibility, and over whom, no power.

As Giddens (1968) observed:

> ".. power is directly derivative of authority; authority is the institutionalised legitimation which underlies power."

The local National Health Service manager was, therefore, in an almost untenable position. Catering, domestic and works services were normally managed on an Area or District basis. Nursing staff were grouped into specialities, rather on an institutional grouping. Unit managers frequently experienced the difficulties of 'managing' several functional heads, all of whom senior to him in organisational terms, each operating separate personnel policies, and each operating an individual management style, often divergent from each other.

The frequent result was that the focus for decision making moved to District or Area level. Trade unions showed preference for referral to District or Area level, as it proved to be the lowest level at which decisions could be made.

This was clearly developing into a major problem, and the reaction was towards the development of training programmes which would develop the skills necessary for the local managers to undertake industrial relations locally.

CENTRALISED TRAINING FOR INDUSTRIAL RELATIONS

TRAINING FOR INDUSTRIAL RELATIONS

The initial indentification of a centralised training programme for industrial relations was made in 1976 (See Appendix 6). The DHSS inititated the 'Cascade' training programme, under the guidance of Lady McCarthy, Vice Chairman of the National Training Council. The principle of the programme was:-

> "aimed at encouraging NHS management at operational level to develop a more cohesive appraoch to their industrial relations responsibilities, so that they may be the better able to engage in constructive dialogue wih all representatives".
>
> (DHSS 1976)

The concept of the 'Cascade' system was developed by DHSS following consultation with Regional Administrators and senior managers of the National Health Service in 1975. The remit within which the DHSS described the scheme was

> "the District Management Teams are the executive line managers and should be given as free a hand as possible to get on with the job, providing they are given clear policy guidelines within which to work".
>
> (R A Seminar Oct 1975)

The DHSS also advised that participants should

> "work out their policies within the appropriate national, Regional and Area Framework, Districts ..... ask these others tiers to specify what that framework is"
>
> (DHSS 1976)

Clearly the intent was to focus attention for responsibility analysis, again concentrating on rigid structural concepts.

However, there was the introduction of the idea to consider relationships.

> "The higher tiers of management are in turn finding that they themselves need, as a matter of priority to determine more clearly than before their respective roles ..... the result can only be beneficial to the organisational development of the NHS, particularly in relation to the personnel function".
>
> (DHSS 1976)

This was the first admission that the interrelationship between functional and line managers was in need of consideration. However, the intial thrust of the 'Cascade' courses was unidisciplinary workshops, each discipline attempting to identify its own needs with regard to training in industrial relations skills.

These who had been invited by the DHSS to attend the intial workshops were then expected to return to their Area or District and precipitate local unidisciplinary workshops - hence the Cascade effect.

By September 1977, Regions were circulated with information concerning the revised training programme (Appendix 7). The circular (RA 77/25) described the constraints, both financial and social, but indicated that its aim was

> "to produce firm recommendations to the Training Council of immediate action on training within the framework of co-ordinated plans for the future"
>
> (DHSS 1977)

The DHSS identified several centres which would provide the resources for the training programme, but did accept that localised training i.e. IPM membership was successfully undertaken individually. The aim was to consolidate the indivdually instigated programmes within a National Framework. The continuation of workshops, now a multi-disciplinary basis, was viewed as the most effective method of training for industrial relations.

The whole tenor of the document is supportive, if rather patronising, Districts being advised concerning selections of staff to attend:-

> "Success within a District can be seen to depend on the presence of interested people with strong personalities yet measures of tact."
>
> (DHSS 1977)

With regard to the interrelationship between line officers and personnel officers:-

> "The personnel function makes a obvious choice for first attention, since it is the prime NHS source of expertise on the subject of managers generally; also personnel officers hava a professional concern to improve the quality of the management of industrial relations; though a rapid build-up of knowledge and skills seems to be required over the service as a whole".
>
> (DHSS 1977)

The areas identified as the bases of training were predominantly 'information items', with a much smaller skills learning element.

The training courses commenced in 1978, dominated by senior representatives

from Personnel and Senior Administrators. (Appendix 8) These courses were held at the academic centres, each of whom had specific responsibility for several health Regions.

By 1979 (See Appendix 9) concern was being expressed that the scheme should be modified to other separate training,

> "first for the personnel specialists at all levels, by maintaining the momentum of the courses already arranged: and secondly, carrying industrial relations training to ultimately all NHS managers, with all the different levels of need and approach that that implies"
>
> (V Jones June 1979)

The programme of courses was viewed that for Personnel staff alone:

> "a minimum of ten more courses will be needed over the next two years if demand is to be met"
>
> (V Jones 1979)

Senior officers of the Service were concerned that the courses were not always keeping pace with events. More thought needed to be given to the philosophy of industrial action, and ways in which they (Regional and Area Staff) should react. Seminars were arranged by the academic centres (Appendix 10) where these issues were discussed.

Again, little if any actual consideration was given to the relationships at local level, between personnel and line managers.

Training programmes on industrial relations were locally organised for Health Authority members, a recognition of their changing role, but again the interrelationships were not always considered.

The formulation of Industrial Relations policy documents was a more unusual development. That defined by West Birmingham Health District was (and remains) a rare exception (Appendix 11). The ethos of the document is the formal acceptance of the role of the District Management Team - and yet the District Personnel Officer is not a member of that team. The only reference to him being:-

> "The District Personnel Officer has a responsibility to advise managers on the provision of equitable facilities in the light of prevailing circumstances .....
>
> Responsibility for identifying and meeting industrial relations training needs within available finance rests with managers. The District Personnel Officer has a responsibility for providing such assistance as is practicable to enable managers to fulfill this role."
>
> (West Birmingham Health District 1979)

The formal provision of training however was under pressure from tthe environmental factors leading to the major 1979 dispute. The training made little or no provision for considering the different tactical methods to which unions were resorting.

Substantive negotiations could only be undertaken on national level on the vital issue of pay, and the disputes were increasingly becoming those of 'rear guard' action at the local level.

It may be argued that the 1979 dispute was made more difficult to centrally monitor because many more local managers, both line and personnel, felt that they had the ability to cope with the situation.

Undoubtedly however, the design of the training programme was felt to be the optimum given the rapidly changing circumstances of industrial relations in the Service. It has never been assessed, in terms of object attainment, nor cost effectiveness. The course however, continue to be offered, and the preperation of a "handbook" is seen as the next major event. The problem of concentrating on mechanics rather than process have not yet been resolved.

SOUTH GLAMORGAN HEALTH AUTHORITY

SOUTH GLAMORGAN HEALTH AUTHORITY 1974-1980

Within Wales, the 1974 reorganisation of the National Health Service included no provision for Regional Health Authorities. The Area Health Authorities were responsible to the Secretary of State for Wales, and the functions which would have been undertaken by a Regional level which were shared by mutual agreement.

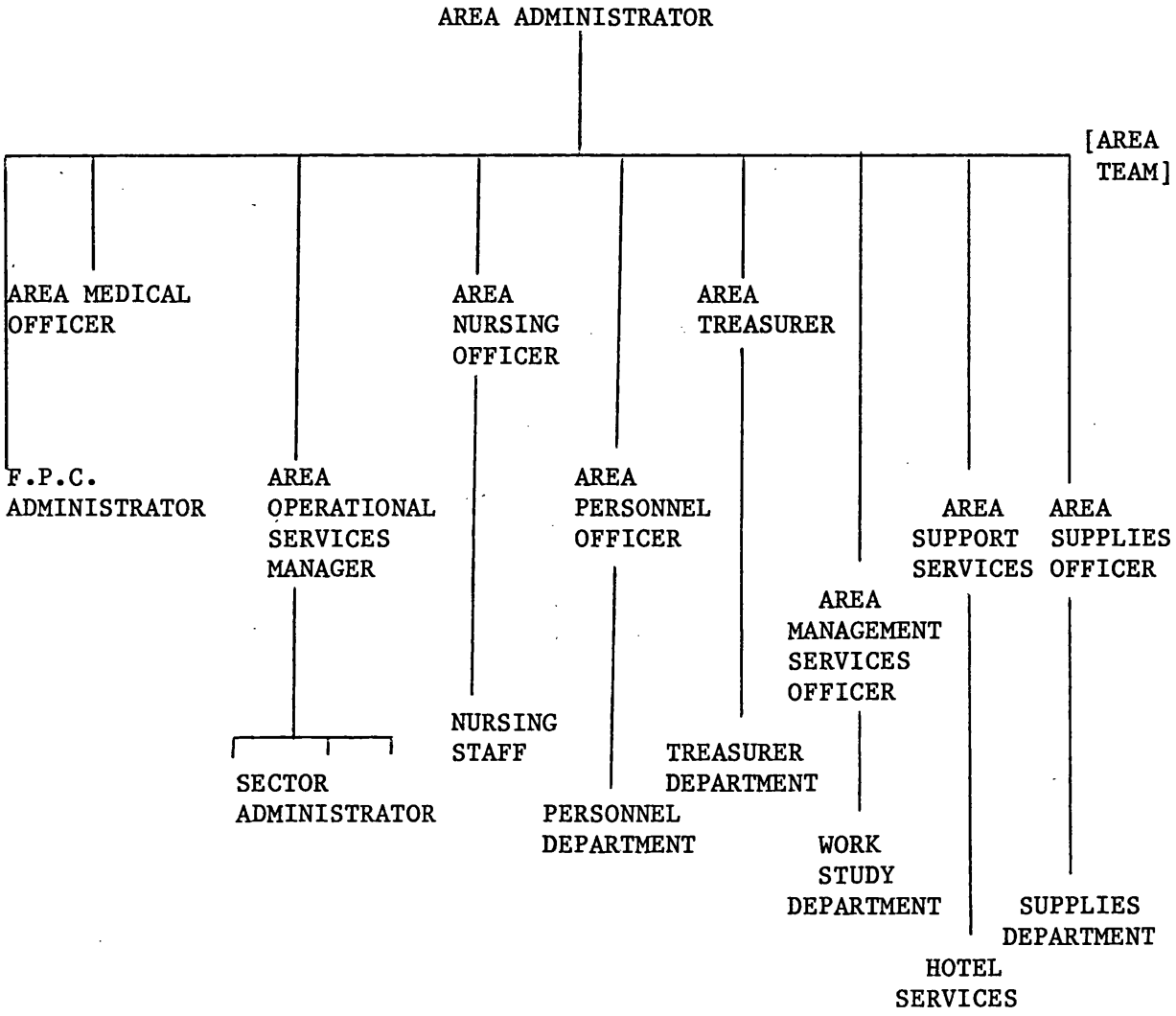
The South Glamorgan Health Authority was the only teaching area in Wales, and was a single district area. It provided the health care service for a population of 392,000 and a wide range of regional and subreigional services for up to 1,500,000 people.

The budget in 1978 totalled £50.00 million revenue allocation, and £1 million capital revenue. Approximately 12,700 staff were employed in 1978 (10,500 whole time equivalents). To fufill its teaching obligation, it provided the Welsh National School of Medicine with clinical facilities for the undergraduate training of medical, dental and nursing degreee students. The Authority was also directly responsible for providing a comprehensive range of training schools and courses for past-graduate medicine, dentistry, nursing, para-medical, administration, and various disciplines in the 'hotel' and ancillary services.

South Glamorgan also provided the facilities for research involving the Health Authority, Welsh National School of Medicine, University College Cardiff, and University of Wales institute of Science and Technology, Medical Research Council, and voluntary organisations ie Tenovus Institute of Cancer Research.

DIAGRAM 1

STRUCTURE OF AREA LEVEL OFFICERS 1974-1980



Because South Glamorgan Health Authority had a teaching function, more divergent staff were employed than would be found in non-teaching areas. Staffing ratios were consequently higher.

The Health Authority ran 17 hospitals and approximately 25 Health Centres throughout Cardiff and the Vale of Glamorgan. The Ambulance Service, and Support Services Centre (Laundry and Sterile Supplies) were also directly operated by the Health Authority.

In three of the hospitals, hospital based personnel staff were employed. They were based in the largest hospitals, and dealt predominantly with interviewing and recruiting staff in conjunction with the local administrators.

The Area Team of Offices (see diagram 1) included the Area Administrator, Medical Officer, Nursing Officer, and Treasurer. The next level of administration involved the Area Personnel Officer, with other functional managers. Each month, the Area Team of Officers would formally meet with their subordinate layer to resolve outstanding problems. Each month, each functional department held a meeting to refer information back from the Area Team meeting. By 1976, it was felt that this type of "committee management" was becoming too unwieldy. An Organisational Development exercise was undertaken, and discovered that each month 157 committee meetings were held within the Area. The majority of meetings were held by administrative staff. Following this exercise, it was decided to rationalise the communications. The effects of this decision were not adversely felt lower in the organisation.

The sector administrators were adminstratively responsible for groups of small hospitals, or one large hospital, and reported directly to the Area

Operational Services Manager.

The Area Administrator was responsible to the Health Authority for the satisfactory provision of Health Care Services in South Glamorgan. The Health Authority also delegated members to be "official visitors" to specific hospitals. These members were expected to visit the hospitals regularly to ensure that services were acceptable.

Following the Organisational Development exercise in 1976, each sectorwas allocated functional "link" specialists. This related particularly to Personnel and Finance, one officer in each functional department would take particular responsibility to actively develop personal contact with the designated sector. In finance, this meant that any queries, whether pay or budgetary, could be directed at one particular officer, and it was his responsibility to resolve that difficulty within the functional department. Also in personnel, any queries could be directed at the link officer, and they would be resolved.

The link officers also had the invitation to become involved in local issues at hospital level, which they may not have been involved in without the existence of the link.

This link arrangement continued until 1978, when it failed due to problems of labour turnover within the personnel department.

Labour turnover was a major factor in the continued functioning of the personnel department. From 1973 to 1977 recruits to the department were all young recent graduates, with no prior experience of the National Health Service. Because of the effects of the 1974 reorganisation, many vacancies continued to arise for administrative line management posts, both within

the Area and elsewhere. The turnover of personnel staff between 1976 to 1980 was 100%, with all those leaving going into line management positions.

The view was obviously held that personnel experience not only improved the individuals general experience, but was becoming the "stepping stone" to administrative experience.

Given this most unusual pattern, the relationship between Personnel Officers and line managers was quite close. The repercussions of the 1974 reorganisation were still being felt by local managers, and the Personnel staff were usually involved only as a "last resort".

The more intrusive action in 1976/77 to monitor the appointment of staff by the manpower planning officer generated overt hostility. As staff vacancies arose, permission was required from the personnel officer to initiate the replacement of staff. The policy was introduced by the Area Personnel Officer to ensure that staff recruitment did not outpace staff budgets.

The later action, initiated locally, to introduce joint consultative machinery throughout the area was viewed with suspicion if not total hostility.

The Personnel Department

The Personnel Department (Diagram 2) had been created in 1974 following reorganisation, but the personnel officers based in hospitals were not considered to be part of the department.

Responsibility for nurse personnel matters was under the auspices of the Area Nursing Officer. Resonsibility for the appointment of Doctors was

held within the Area Headquarters, although the personnel department was involved with all appointments - authorising payments under Whitley Council agreements.

The training function was undertaken by the Area Training Officer and staff.

Within the 'Manpower' Section, functional responsibility was held by relatively junior staff (Senior Administrative Assistants) in the areas of:

i) Employment Practices

ii) Industrial Relations

iii) Manpower Planning

Employment Relations Section

Within this section, all matters relating to the interpretation of Whitley Council agreements were covered. This included advising on advertising, interviewing, and implementing the conditions of service which allowed for payments to staff, e.g. removal expenses.

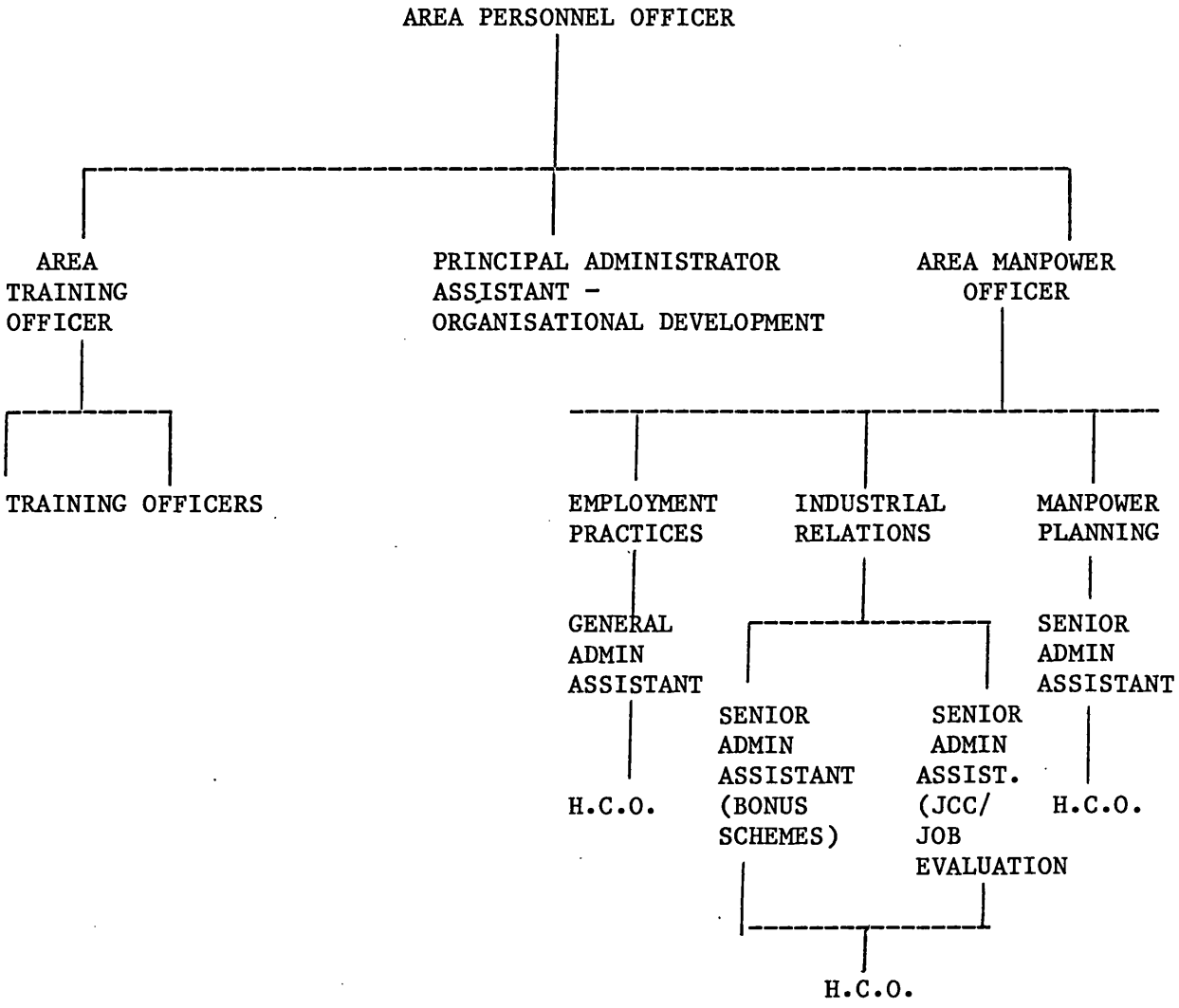
Industrial Relations Section

One member of staff was particularly involved in the introduction of bonus schemes, both interim and work studied. With the growth of schemes, this became an almost full time activity.

The other personnel officer was responsible for job evaluations throughout the area, and the introduction of joint consultative machinery. Concommitant with this was the Secretariat function for the monthly meetings with Trade Union officers and the Professional organisations representatives.

DIAGRAM 2

STRUCTURE OF AREA PERSONNEL DEPARTMENT 1974-1980



Manpower Planning

The personnel officer employed within this section undertook to record manpower plan targets against performance.

Given the functional breakdown of responsibilities it is apparent that estrangement could have arisen, between personnel staff and the line managers.

However, the Area was geographically small, and transport was not difficult Therefore, the Area Personnel Officer actively encouraged staff to become involved in units throughout the area.

The majority of sector and unit administrators were relatively young (Potter 1976) but most had been in post in South Glamorgan prior to reorganisation.

Whilst the Personnel staff were young, all were new to the area, except for the Area Manpower Officer. For this reason, there was a high trust relationship, between line managers and the Manpower Officer.

To exemplify the functioning of the industrial relations element of personnel management, two example will be given of disputes which were local to South Glamorgan.

Disciplinary Case

The case notes are contained in Appendix 12, but the case itself was interesting for several reasons. By 1976, the concept of fair and unfair dismissal was becoming established.

A member of the engineering staff in South Glamorgan was told to report to

a different hospital for duty following disciplinary action. The other engineering staff refused to work with the relocated employee, and the Health Authority in pursuance of its obligation to maintain the service, dismissed the employee, totally unfairly. All recourse to procedures of Appeal was witheld - again unfairly. The employee sought redress via the Health Authority, and appealed to an Industrial Tribunal.

The outcome of the tribunal is recorded, but it was clear from the way in which the case was dealt with that local managers did not feel that the legislative framework was always antagonistic. It was felt that the Personnel Officer had "won" and that victory was shared by line managers. Despite line managers later hesitation about industrial tribunals, the case described improved the esteem of the personnel function to line managers. The Health Authority responded cautiously to the request for appeal machinery to be instigated, but by 1979 had become more intrusive in industrial relations during the dispute of 1979.

ACAS Involvement in Ambulance Dispute

During October 1976 and July 1977, the Ambulance service were in dispute with the Health Authority. The causal factors were cumulative and in August 1977, the trade unions requested ACAS to:

> "inquire into the industrial relations arrangements and their implementation within the ambulance service of the South Glamorgan Area Health Authority and to report with recommendations for improvement where appropriate."

The survey was undertaken during a period of continuing dispute between the Authority and the Ambulancemen, and the underlying conflict between two of the unions represented.

The summary of recommendations from ACAS are contained in Appendix 13. The negotiations during the dispute were undertaken by the personnel department, as the ambulance service managers were extremely hesitant to become involved at all.

It is pertinent to consider that by this time (1977) although the national training scheme for industrial relations had been in operation for two years - no South Glamorgan staff had been allowed to participate.

The problems which they dealt with were accentuated because of the teaching role of the Area, and the political problem of the then Prime Minister being an M.P. for part of the area covered by the Health Authority.

The personnel function was established and maintained purely on a local basis of regard and esteem for role holders - who demonstrated their abilities as exemplified in the cases described.

Analysis

The interrelationships between the Personnel department and the line managers was extremely buoyant, especially during the period 1974-1977.

Towards the end of the period under consideration, i.e. 1979-80, the staff changes previously described had taken place, thus changing the relationships. Previous personnel officers were now line managers (in four of the main hospitals) and there was little regard for the skill or expertise of those appointed into the vacancies.

In 1977, the Area Personnel Officer moved to a line administrative function, thus the previous superordinate/subordinate relationship was re-

established for the four ex-personnel officers now line managers. This factor did little to engender the development of positive contacts between the new personnel staff and the line managers. The style of management encouraged was one of self containment of all but the most intractable problems.

This approach was reinforced, during the disputes of 1979, when the sole function allowed to the personnel department were those of communication links - all local negotiations being undertaken by the local line managers.

DISCUSSION

DISCUSSION

The problems encountered by the National Health Service in resolving its industrial relations problems, are dominated by the problems of interrelationship between line managers and the personnel specialist.

Little research has been undertaken into the management of the Health Service, so examples from industry must be considered.

Marsh et. al. (1977) observed that line managers in the engineering industry refused to delegate responsibility for procedural matters to personnel specialists. Poole (1978) reported that at floor level, managers and shop stewards:

> "rarely sought the advice of personnel managers on industrial relations questions"
>
> (1978)

In a study of 45 factories, Turner et al (1977) observed:

> "no link between the number of personnel and industrial relations specialists and the level of industrial harmony."
>
> (1977)

Legge (1978) observed:

> "Ambiguities in definition generate confusion at the operational level about the nature and focus of personnel management responsibilities, which in turn promotes a lack of coherence in the allocaction of personnel activities and gives rise to critical assessment of the function."
>
> (1978)

But referring to British Leyland, Pat Lowry observed,

> "Over the last ten or twenty years line management has opted out of the personnel function. The attitude has been that we employ personnel managers. They should get on with it. In fact personnel work is far too important to be left to personnel people."
>
> (Guardian 10-7-80)

Implicit within this statement is the distinction between personnel activity - the management of human resources at work, and the activities carried out by personnel staff.

The Institute of Personnel Management defined Personnel Management as

> "..... a responsibility of all those who manage people, as well as being a description of those employed as specialists. It is that part of management which is concerned with people at work, and with their relationship within an enterprise."
>
> (IPM 1963)

As Lowry indicated, there is ambiguity and tension in industry about which aspects of personnel management should be left to specialists. Woodward (1965) observed:

> "It was in relation to personal management that the problems and dilemmas associated with the line-staff concept occurred in their most extreme form."
>
> (Woodward 1965)

As has been shown, the predominant role of the Personnel Officer in the National Health Service during the period 1974 until 1980 has been in

industrial relations. Whilst describing industrial enterprises, Turner et al (1977) commented:

> "one reason for the comparatively low ratio of personnel specialists in the bigger enterprise is that much of their function is taken over by the shop steward system."

And yet this does not adequately describe the experience of the National Health Service. More accurately,

> "Structure of managerial organisation would clearly seem to affect propensity to strike in the enterprise. After all, strike incidence would appear to be positively correlated with "standardisation" and "formalisation" in general management and especially with "formalisation in industrial relations".
>
> (Turner et al 1977)

The National Health Service was subjected to the major structural reorganisation in 1974, which reinforced the power of the centralised formal system and was therefore inevitably going to experience greater incidents of localised dissatisfaction. Some of the events were caused by the interpretation of agreements which had been nationally agreed.

Others were caused by the effects of external, environmental factors, ie changes to the legislative framework affecting employment, and Government Pay Policy which prompted greater union organisation and activity. One major factor during the period 1974 to 1980 was the changing power relationship of the parties involved. Far from having a unitary frame of objectives within the overall 'provision of health care' a seemingly continous fragmentation of objectives led to hyperplurality.

At local levels the line managers were given the responsibility for the provision of health care services within financial constraints. The effectiveness of the service was maintained not only by line superiors, but also by the public via Health Authority members and Community Health Councils. Staff groups became aware that pressure could be exterted on management via these "lay" but powerful bodies.

Indeed the very term 'the managers' implies a degree of homogeneity which is difficult to accept. As Mansfield described:

> "In reality by almost any conceivable definition management is a lightly heterogenous group, with a greatly varying remuneration, prestige and access to power."
>
> (1969)

Fox (1971) identified that changes in the balance of power could materially affect managerial strategy, and

> "broadly speaking, a gradual shift from unitory to pluralist perspectives in industrial relations among managerial personnel could be identified."
>
> (1971)

This view was consolidated in his later research (1974). It is interesting to note that this move towards pluralism reflected shifts of power in the organisation, whereas in the National Health Service pluralism offered greater power. The concept of power may also be related to understanding the strategy operated by local managers. The rigid authoritarian structures which existed prior to 1974, were still in existence. The local manager had responsibility but very little power. The period of 1974 until 1980 demonstrated the exploration of the power base, predominantly through

the practice of industrial relations. The relationship therefore, between the personnel officer and line manager was critical.

Personnel was never viewed by the DHSS in career terms, HM (72) 65 whilst delineating the 'Development of the Personnel function'. points out

> "..... a sound knowledge and experience of personnel management must be looked for in candidates for top management posts .....
>
> acceptance of a post in the personnel field should not be seen as a stepping aside from the mainstream of advancement; on the contrary a period spent there is likely to increase an officers understanding both of the diverse tasks of the service ..... and of the variety of human attributes which people bring to them. It thus forms a valuable preparation for senior posts."
>
> (DHSS 1972)

In 1974 reorganisation caused major upheaval with staff being obliged to apply for all posts. There was therefore much geographic and heirarchical movement, with many line managers being appointed who had previous (although limited) personnel experence. Of course the movement from line to personnel management occurred, therefore interrrlationships had to be formed on purely mutual esteem.

Many line mangers were therefore hesitant to accept an intrusive role by the personnel managers, and concentrate on local issues by themselves.

This then predestined some personnel departments to adopt Druckers (1955) view that:

"personnel administration consists of a collection of minor activities which no one else wants or do not fit in easily elsewhere. These include matters such as, safety, welfare, sports and social facilities.

However, one of the major causal factors of improving the status of personnel specialists was the increase of legislation governing employment. This was particularly apparent in disciplinary and greivance matters. With increased union membership, staff were better advised of their employement 'rights' under law.

As Fewtell (1980) observed,

"The role of the personnel department provides districts with a dilemma between industrial relations, safety first and real reponsibility for local managers. This objective problem can be further exacerbated if indifferent managers are willing to abdicate their responsibilities to a personnel department which is anxious to establish itself and build up its influence .....

Perhaps the best compromise is to build into managers guidance the obligation to consult the personnel department before decisions are taken on final warnings or dismissals ..... guarding against most managerial aberrations without emasculating the authority of departmental heads."

(Fewtrell 1980)

Fewtrell also observed:-

"Personnel departments seem to have adopted a more active role ..... this perhaps reflects their customary position as critical or unofficial courts of appeal for aggrieved staff".

The development of industrial tribunals was also a causal factor in the evolution of the role of Personnel officers in industrial relations. The technique of case presentation were included in the DHSS training programmes but were particularly orientated towards personel staff. As the line manager was the dismissing authority for staff, the personnel officer was usually felt to be the "honest broker" who could impartially present the cases at tribunal. This development verifies Drucker (1955) but also Fewtrell (1980) in the degree to which personnel managers accepted or overtly sought such responsibility, and ultimately power.

The view that power was a tangible resource which could move between protagonists in industrial relations was widely held. Yet the period 1974 until 1980 in terms of Health Service management was one of greatly varying power loci, most of the apparent changes being intraorganisational.

The formal structure of heirarchical power in organisation has rarely been discussed, except in descriptive terms, eg Tannembaum et al. (1974). The abstract concept was proposed by Crozier (1964) drawing heavily upon the "behavioural theory of the firm" as proposed by Cyert and March (1963). Lawrence and Lorsch (1967) and later Hickson (1971) suggested that organisational power does not exist in heirarchical pyramidal from, but in the 'interdepartmental system'-

> "the division of labour becomes the ultimate source of intra-organisational power, and power is explained by variables that are elements of each sub units task, its functioning, and its links with the activities of other subunits."
>
> (1971 Hickson et al)

The relationship between the DHSS and the Health Authorities was also undergoing major change. There was a major estrangement following the advent of the Conservative Government. The overt Government changes in stance towards the National Health Service Service resulted in many local managers experiencing major difficulties. Locally, pressure was exerted via the Health Authority and Community Health Councils, which was more acutely felt by the managers.

The DHSS in response to pressure at national level via the Whitley Council issued advisory notes about the introduction of union membership agreements, and joint consultative machinery.

On both issues, this delegation of authority by the DHSS was strongly resented by the local managers. At local level, the trade unions were marginally in favour of union membership agreements, but almost totally against joint consultative machinery. This management were almost totally against both propositions. The personnel staff had no power to install joint consultation - but were delegated with the responsibility. The requests for union membership agreements had to originate from full time officers of trade unions, and requests did not readily appear - a sympton of the extreme rivalry between unions.

The effects of this was often to generate strained relationships between line managers and the personnel specialist, as the line managers viewed the activity as an intrusion into their authority.

It is intresting to note that personnel specialists who offered support, ie for the negotiation of the introduction of incredibly complicated bonus schemes, were not viewed as challenging the 'managers right to manage'.

The majority of personnel specialists were not located in, or given responsibility, for, individual hospitals. This factor reinforced the image of being remote and not necessarily sensitive to the day to day management problems of units. Within personnel departments, functional breakdown of responsibilities i.e. terms and conditions of employment, manpower planning, industrial relations, training - were often necessary, but not always desirable.

Whilst some Health Authorities decentralised their departments during this period, making personnel officers responsible to the unit managers, this was seen as a retrograde step in terms of the quality of service to be given. The work of the previous years in establishing "centres of excellence" could be irretrievably damaged, due to the role overload of the few officers remaining at the centre.

CONCLUSIONS

CONCLUSIONS

It is quite clear that when the DHSS issued Circular HM (72) 65, the view was that a strictly regulated centralised organisation, with a personnel adjunct, would cope with the management demands which it encountered.

However, the experience of 1974 to 1980 showed the fallacy of this hypothesis. It may be accepted that the National Health Service was subjected to a number and range of pressures, which no organisation could satifactorily withstand. The maintenance of concentration on structure though, exacerbated the difficulties which were experienced and resulted in potentially damaging fragmentation. The Government response, in the reorganisation of 1982, was again to restructure - and again to ignore the obvious warnings that the inter and intrarelationships desperately needed consideration and consolidation.

The response to felt needs in terms of industrial relations was the establishment of the Cascade training programme - but to date no objective evaluation has been made of its effectiveness.

The local managers of the service cannot effect change at the base of power in the DHSS, and yet there is evidence that misgivings are now being publically voiced when it is felt that centralised policy is not sensitive to local demands.

It is however, difficult to anticipate from where the successful pressure for change will emanate.

ABBREVIATIONS

ABBREVIATIONS

ACAS	Advisory Conciliation and Arbitration Service
ASTMS	Association of Scientific, Technical and Managerial Staffs
BMA	British Medical Association
COHSE	Confederation of Health Service Administrators
DHSS	Department of Health and Social Security
NUPE	National Union of Public Employees
RCM	Royal College of Midwives
Rcn	Royal College of Nurses of the United Kingdom
TGWU	Transport and General Workers Union
USDAW	Union of Shop, Distributive and Allied Workers

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E.G.A. ARMSTRONG	Straitjacket or Framework 1973
BERRIDGE J	Lecture on Industrial Relations June 1975
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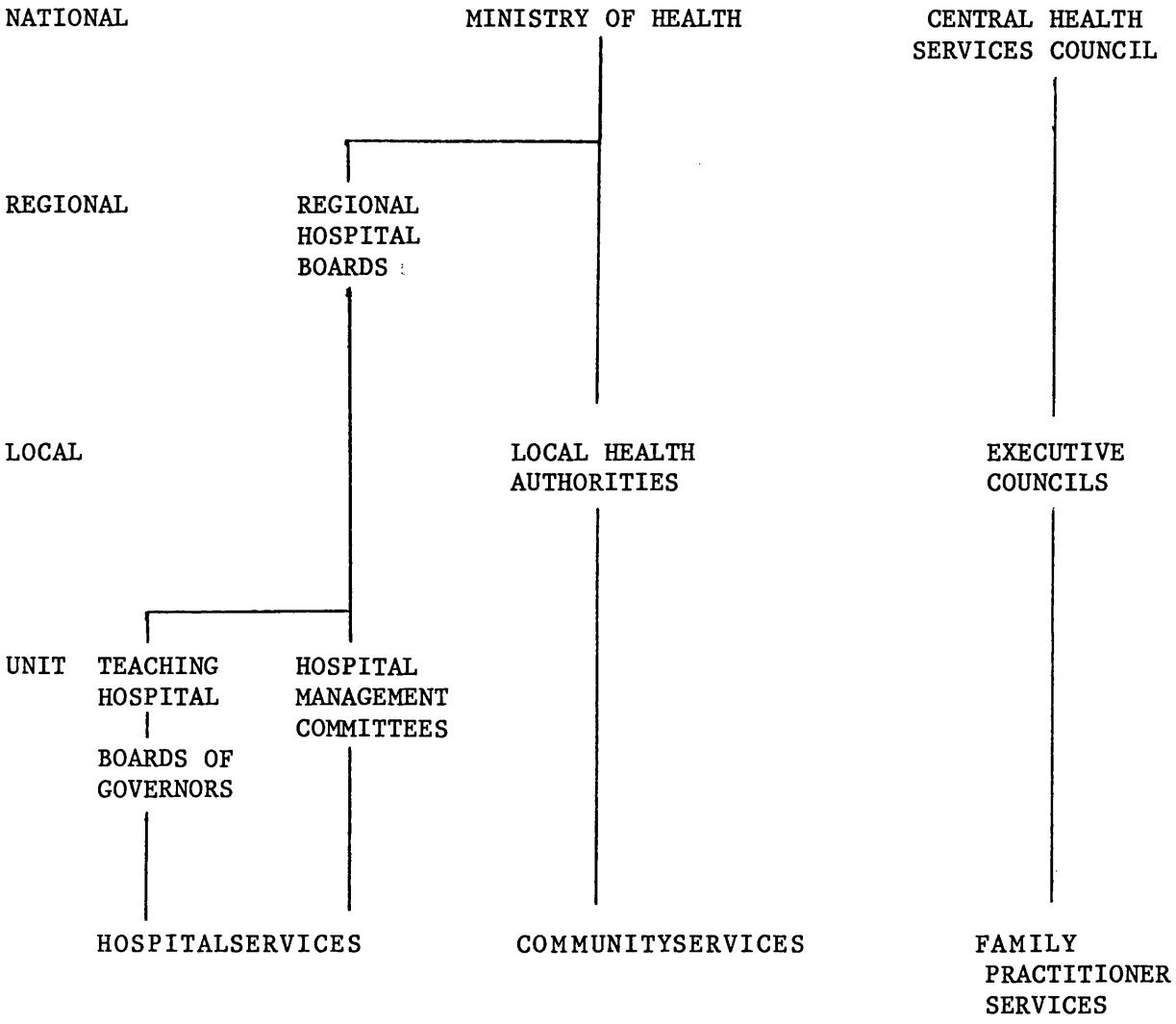
APPENDICES

Appendix 1 (a)

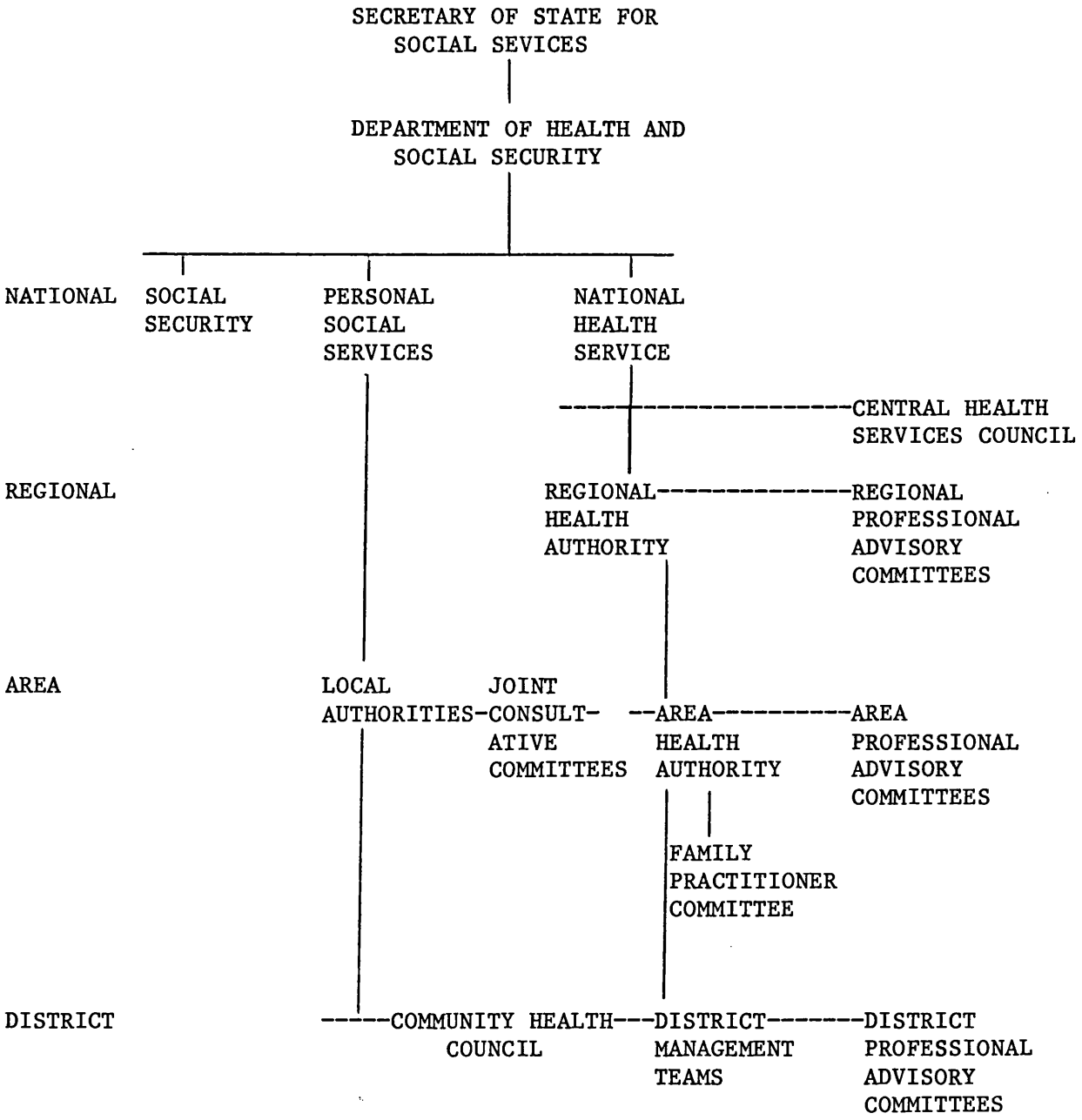
THE NATIONAL HEALTH SERVICE 1948-1974



(THE REORGANISED NATIONAL HEALTH SERVICE - R. LEVITT)

Appendix 1 (b)

THE NATIONAL HEALTH SERVICE 1974-1982



(MANAGEMENT ARRANGEMENTS FOR THE REORGANISED NATIONAL HEALTH SERVICE

HMSO 1972.)

Appendix 2 (a)

Source: Making Whitley Work - Lord McCarthy DHSS 1976

NATIONALLY RECOGNISED NEGOTIATING BODIES

Association of Building Technicians
Association of Clinical Biochemists
Association of Dispensing Opticians
Association of Hospital and Residential Care Officers
Association of NHS Officers
Association of Nurse Administrators
Association of Optical Practitioners
Association of Scientific, Technical and Managerial Staffs
Association of Supervisors of Midwives
British Association of Occupational Therapists
British Dental Association
British Dietetic Association
British Medical Association
British Orthoptic Society
Chartered Society of Physiotherapy
Company Chemists Association Ltd
Confederation of Health Service Employees
Co-operative Union Ltd
General and Municipal Workers Union
Health Visitors' Association
Hospital Physicists' Association
Institute of Health Service Administrators
National and Local Government Officers Association
National Pharmaceutical Union
National Union of Gold, Silver and Allied Trades
National Union of Public Employees
Pharmaceutical Standing Committee (Scotland)
Royal College of Midwives
Royal College of Nursing and National Council of Nurses of the United Kingdom
Scottish Association of Nurse Administrators
Scottish Health Visitors' Association
Scottish National Committee of Ophthalmic Opticians
Socialist Medical Association (Ophthalmic Group)
Society of Administrators of Family Practitioners Services
Society of Chiropodists
Society of Opticians
Society of Radiographers
Society of Remedial Gymnasts
Transport and General Workers' Union
Union of Shop, Distributive and Allied Workers

and, in addition, the following bodies that conduct negotiations with the Department in respect of maintenance workers:

Confederation of Shipbuilding and Engineering Unions
Electrical, Electronic and Telecommunications' Unions and Plumbing Trades' Union
DHSS Building Craftsmen's Committee Trade Union Side—Hospital Maintenance

Appendix 2 (b) (i)

Source: Making Whitley Work - Lord McCarthy DHSS 1976

APPENDIX B CONSTITUTION OF WHITLEY COUNCILS AND OTHER NOMINATING BODIES

1. General Council

On both sides membership is based on nominations from the functional councils. The precise composition of the Management Side can therefore vary but for example for the year 1975/76 it was:

Management Side	
Regional Health Authorities	10
Area Health Authorities	9
Scottish Health Authorities	5
Welsh Health Authorities	5
DHSS	3
SHHD	1
Welsh Office	1
	34

of whom
2 are officers of RHAs
2 are officers of AHAs

The constitution provides for the following minimum representation:

Regional Health Authorities	6
Area Health Authorities	7
Scottish Health Authorities	5
Welsh Health Authorities	3

Staff Side	
Administrative and Clerical Council	3
Ambulancemen's Council	2
Ancillary Staffs Council	3
Medical and (Hospital) Dental Council	4
Nurses and Midwives Council	4
Optical Council	1
Pharmaceutical Council	2
Professional and Technical Staffs Council 'A'	3
Professional and Technical Staffs Council 'B'	3
Community Dental	1
	26

Secretary NALGO

2. Administrative and Clerical Staffs Council

Management Side	
Regional Health Authorities	4
Area Health Authorities	7
Scottish Health Authorities	3
Welsh Health Authorities	1
DHSS	3
SHHD	1
Welsh Office	1
	20

No officers serve on the Management Side

Staff Side	
Association of Hospital and Residential Care Officers	1
Association of NHS Officers	2
COHSE	4
IHSA	4
NALGO	15
TGWU	1
Managerial, Administrative, Technical and Supervisory Association	1
NUPE	4
Association of Administrators of Family Practitioner Committees	1
	33

Secretary NALGO

Appendix 2 (b) (ii)

Source: Making Whitley Work - Lord McCarthy DHSS 1976

3. Ambulancemen's Council

Management Side		*Staff Side*	
RHAs responsible for metropolitan ambulance services in England excluding area served by London Ambulance Service	3	NUPE	8
RHAs which include area served by London Ambulance Service	2	GMWU	5
Area Health Authorities	5	TGWU	5
Welsh Health Authorities	1	COHSE	1
Common Services Agency (Scotland)	2		19
DHSS	3		
SHHD	1	Secretary NUPE	
Welsh Office	1		
	18		

of whom
1 is an officer of the London Ambulance Service
1 is an officer of an AHA

4. Ancillary Staffs Council

Management Side		*Staff Side*	
Regional Health Authorities	4	COHSE	4
Area Health Authorities	6	GMWU	4
Scottish Health Authorities	3	NUPE	4
Welsh Health Authorities	1	TGWU	4
DHSS	3		16
SHHD	1		
Welsh Office	1	Secretary NUPE	
	19		

of whom
2 are officers of RHAs
2 are officers of AHAs
2 are officers of Health Boards in Scotland

5. Dental (Local Authorities) Council

Does not meet. Constitution not amended since NHS reorganisation.

6. Joint Negotiating Forum for Community Dentists

Management Side		*Staff Side*	
DHSS	2	British Dental Association	12
SHHD	1		12
Welsh Office	1		
	4	Secretary BDA	

No employing authorities.
No officers

Appendix 2 (b) (iii)

Source: Making Whitley Work - Lord McCarthy DHSS 1976

7. Medical and (Hospital) Dental Council

Does not meet. Constitution not amended since NHS reorganisation.

8. Joint Negotiating Committee for Hospital Medical and Dental Staff

Management Side		*Staff Side*	
DHSS	5	Negotiating sub-committee of Central Committee for Hospital Medical Services of BMA	21
SHHD	1	Negotiating sub-committee of Hospital Junior Staffs Committee of BMA	5
Welsh Office	1		26
	7		

No employing authorities
No officers

Secretary BMA

9. Joint Negotiating Body for Doctors in Community Medicine and the Community Health Services

Management Side		*Staff Side*	
DHSS	5	Negotiating sub-committee of Central Committee for Community Medicine of BMA	7
SHHD	1		7
Welsh Office	1		
	7		

No employing authorities
No officers

Secretary BMA

10. Nurses and Midwives Council

Management Side		*Staff Side*	
Regional Health Authorities	5	Association of Nurse Administrators	1
Area Health Authorities	6	Association of Hospital and Residential Care Officers	1
Scottish Health Authorities	3	Association of Supervisors of Midwives	1
Welsh Health Authorities	1	COHSE	4
DHSS	3	Health Visitors' Association	2
SHHD	1	Managerial, Administrative, Technical and Supervisory Association	1
Welsh Office	1	NALGO	2
	20	NUPE	4
		Royal College of Midwives	3
		Royal College of Nursing	8
		Scottish Association of Nurse Administrators	1
		Scottish Health Visitors' Association	1
			29

of whom
1 is an officer of an RHA
2 are officers of AHAs
1 is a District officer

Secretary RCN

ppendix 2 (b) (iv)

ource: Making Whitley Work - Lord McCarthy DHSS 1976

11. Optical Council

Management Side	
Regional Health Authorities	5
Area Health Authorities	3
Boards of Governors	1
Scottish Health Authorities	2
Welsh Health Authorities	1
DHSS	5
SHHD	2
Welsh Office	1
	20

No officers

Staff Side	
Association of Dispensing Opticians	1
Joint Committee of Ophthalmic Opticians	7
Association of Optical Practitioners	4
ASTMS	2
Parliamentary Committee of the Co-operative Union	2
Socialist Medical Association (Ophthalmic Group)	2
Society of Opticians	2
Scottish National Committee of Ophthalmic Opticians	2
	22

Secretary, Association of Optical Practitioners

12. Pharmaceutical Council

Management Side	
Regional Health Authorities	5
Area Health Authorities	3
Boards of Governors	1
Scottish Health Authorities	2
DHSS	5
SHHD	2
Welsh Office	1
	20

No officers

Staff Side	
ASTMS	8
COHSE	2
Pharmaceutical Standing Committee (Scotland)	6
Company Chemists' Association Ltd	1
Co-operative Union Ltd	1
	18

Secretary ASTMS

13. Professional and Technical Council 'A'

Management Side	
Regional Health Authorities	4
Area Health Authorities	6
Scottish Health Authorities	3
Welsh Health Authorities	1
DHSS	3
SHHD	1
Welsh Office	1
	19

of whom
2 are officers of AHAs

Staff Side	
Association of Clinical Biochemists	1
ASTMS	2
British Association of Occupational Therapists	2
British Dietetic Association	1
British Orthoptic Society	1
Chartered Society of Physiotherapy	4
COHSE	2
Hospital Physicists' Association	1
NALGO	2
NUPE	2
Society of Chiropodists	1
Society of Radiographers	2
Society of Remedial Gymnasts	1
	22

Secretary NALGO

ppendix 2 (b) (v)

urce: Making Whitley Work:- Lord McCarthy DHSS 1976

14. Professional and Technical Council 'B'

Management Side	
Regional Health Authorities	5
Area Health Authorities	6
Boards of Governors	2
Scottish Health Authorities	3
Welsh Health Authorities	1
DHSS	3
SHHD	1
Welsh Office	1
	22

of whom
1 is an officer of an RHA
3 are officers of AHAs
1 is a District officer
1 is an officer of a Health Board

Staff Side	
ASTMS	3
COHSE	3
NALGO	3
NUPE	3
National Union of Gold, Silver and Allied Trades	3
Union of Shop Distributive and Allied Workers	3
Association of Building Technicians	3
	21

Secretary COHSE

NOTES:

1. NHS Maintenance Staff.

The DHSS, SHHD and the Welsh Office, in consultation with health authorities, negotiate directly with the National Officers of the recognised Trade Unions representing craftsmen and certain semi-skilled operatives working in the NHS. There is no written constitution for this machinery.

2. Family Practitioner Services.

The family practitioner services are provided by doctors, dentists, pharmacists and opticians who are independent contractors and not employees. Negotiations are conducted directly by DHSS, SHHD and Welsh Office with representatives of the profession concerned, at meetings appropriately constituted for the purpose concerned.

Appendix (3)

COMPARISON OF DAYS LOST THROUGH STRIKE ACTION IN THS NHS WITH THE WORKSFORCE AS A WHOLE GREAT BRITAIN 1966-1977

YEAR	NUMBER OF STAFF	NUMBER OF STOPP-AGES	NUMBER OF STAFF INVOLVED	NUMBER OF DAYS LOST	AVERAGE NUMBER OF LOST PER 1000 NHS STAFF	AVERAGE NO OF DAYS LOST PER 1000 EMPLOYEES IN G.B.
1966	728,838	2	500	500	0.69	100.0
1967	753,486	1	78	200	0.27	124.7
1968	761,747	1	80	80	0.11	211.4
1969	778,998	8	2500	7000	8.99	309.1
1970	792,307	5	1300	6700	8.46	499.2
1971	799,673	6	2900	4700	5.88	625.9
1972	831,753	4	9700	9800	117.8	1104.3
1973	843,119	18	5900	29800	353.5	324.4
1974	859,468	18	4070	23000	26.84	661.5
1975	910,068	19	6000	20000	21.88	270.6
1976	954,877	15	4440	15000	15.86	149.3
1977	970,900	21	2970	8200	8.44	448.0

(ROYAL COMMISSION ON THE NATIONAL HEALTH SERVICES 1979)

APPENDIX 4 MPO/73/35

ARRANGEMENTS FOR MONITORING THE NHS INDUSTRIAL RELATIONS CLIMATE

Further to the discussion at our last meeting recorded in paragraphs 42-44 of MPO/73/28, attached is a draft letter we propose to send to Regional Administrators. It would be useful, before proceeding, to have any comments on the draft from Regional Personnel Officers.

DHSS/P4C July 1973

DRAFT

REGIONAL ADMINISTRATORS
COPIES TO SECRETARIES, BOARDS OF GOVERNORS

Dear Regional Administrator,

ARRANGEMENTS FOR MONITORING THE NHS INDUSTRIAL RELATIONS CLIMATE

You will recall that we proposed to discuss with Regional Personnel Officers the establishment of an information system for monitoring the climate of industrial relations within the NHS. Such information would be extremely valuable to Ministers and to management at all levels, not least because it would facilitate the identification at an early stage of general trends which might be susceptible to remedial action. At present, this information quite simply is not available in a sufficiently comprehensive form, either nationally nor regionally. The Department of Employment do of course collect statistics about major stoppages, with the results indicated in the Annex to this letter: but on account of the somewhat haphazard way in which these figures are notified to DE, their reliability must be open to doubt.

When we discussed this matter with RPOs on 18 May, they said they would welcome an approach from the Department, and they asked that there should be a "feedback" of the national picture to Regions. Accordingly, I am writing to suggest that form in which this information - both statistical and narrative - should be reported each quarter.

1. A statistical return, as attached, which reports the extent of stoppages during the preceeding three months. For these purposes we have adopted the Department of Employment definition, ie stoppages involving ten or more employees and lasting 24 hours or more, or any in which the aggregate number of man-days lost is over 100.

2. Any additional information about any stoppages (official or unofficial) involving fewer than ten employees or which lasted for less than 24 hours; or about any other interruptions (official or unofficial) to normal working, e.g. go-slow; overtime bans; work-to-rule; situations where there are significant implications for particular services and for the NHS generally.

3. A brief narrative impression of the industrial relations climate within the Region during the quarter under review. This should include coverage of any conflict between staff organisations that are affiliated to the TUC and those that are not.

If you agree, I suggest this procedure should be adopted as from 1 October 1978. Thus, the first reports - which should be sent to Mr R K Westbrook (Room 420, Friars House) - would cover the period October - December 1978 and should be submitted by end-January 1979. Given the timely submission of Regional reports we would hope to be able to issue a national summary by end-February 1979.

One last point: in the case of major industrial disputes, the reporting arrangements set out in the Procedure Note I sent you in February will continue to apply.

This letter is copied to the Secretaries of the Boards of Governors, with the request that they too should send Mr Westbrook quarterly returns on the basis suggested.

Yours sincerely

M G Lillywhite

		NUMBER OF STOPPAGES	NUMBER OF STAFF INVOLVED	NUMBER OF DAYS LOST	DAYS LOST/ PERSON INVOLVED DISPUTE/	NUMBER OF DAYS LOST/ WORKER
1973	Total Public Sector	603	518,812	1,503,429	< 0.01	0.22
	NHS	19	59,285	297,762	0.26	0.26
	Local Authorities	109	59,087	174,519	0.03	0.06
	Central Government	8	200,142	168,812	0.10	0.27
1974	Total Public Sector	543	519,791	6,992,835	0.02	1.02
	NHS	18	4,070	23,378	0.32	0.02
	Local Authorities	129	80,168	511,629	0.05	0.19
	Central Government	4	8,438	4,485	0.13	0.01
1975	Total Public Sector	466	152,066	786,369	0.01	0.11
	NHS	20	6,017	20,305	0.17	0.02
	Local Authorities	79	48,775	482,374	0.12	Not Available
	Central Government	13	3,053	7,529	0.19	0.01
1976	Total Public Sector	538	136,860	510,217	0.01	Not Available
	NHS	15	4,441	14,931	0.22	0.01
	Local Authorities	101	15,423	106,161	0.07	0.04
	Central Government	3	163	534	1.09	< 0.01

INDUSTRIAL ACTION IN THE PUBLIC SECTOR 1973-76

Notes

1. These figures relate to the UK.

2. Local authority health functions have been included in the NHS figure. It is therefore possible that some stoppages have been counted twice. This will have occurred when a stoppage involved staff of a class employed by both health/hospital authorities and local authorities.

3. "Stoppages" excludes those involving fewer than 10 workers and those which lasted for less than one day, except any in which the aggregate number of man-days lost exceeded 100.

4. Entries in the last column for 1976 concerning Local Authorities include groups of people not previously classified as LA employees.

ANNEX A

INDUSTRIAL STOPPAGES QUARTER ENDING .....

..... REGIONAL HEALTH AUTHORITY/..... BOARD OF GOVERNORS

DISTRICT AND HOSPITAL (RHAs only)	WHETHER OFFICIAL OR UNOFFICIAL	UNIONS INVOLVED	TYPE(S) AND GRADE(S) OF STAFF INVOLVED	NUMBER OF STAFF INVOLVED	NUMBER OF DAYS LOST	BRIEF INDICATION OF NATURE OF DISPUTE	BRIEF DETAILS OF HOW RESOLVED	ANY OTHER COMMENT

NUMBER OF STOPPAGES ..... AND TOTAL DAYS LOST .....

* Defined either as stoppages involving 10 or more employees and lasting 24 hours or more or as stoppages in which the aggregate number of man-days lost is over 100

NOTES FOR RHA AND AHA MEMBERS ON THE PERSONNEL FUNCTION

(This paper brings together some material - originally prepared for other purposes - which may help members appreciate the personnel needs of the NHS and in particular the special part which, in the Department's view, members should play in this field.)

I THE STAFF OF THE NHS

1. Members will know the different backgrounds of the staff of the new Health Authorities, the great majority of whom come from the hospital service: they will know there is some unease among local authorities' staff at the prospect of a "hospital take over". It is thus most important to make it clear from the earliest stage that this is an integrated service, and indeed many of those now coming under the same paymaster will have been collaborating with each other under different statutory arrangements for years; but it will nevertheless take some time for staff to realise that they are all part of one service. This is so important that Authorities need to devise ways and means of demonstrating that this is a reality e.g. by the conscious sharing of facilities, by arranging social functions which demonstrate the full integration of the service, as well as in any speeches. C.F. the way Eisenhower welded the allied high commands together. We shall look to the Staff Commission and the new National Staff Committees foreshadowed in paragraph 150 of the White Paper to recommend promotion and appointment arrangements which will be accepted as fair to all staff whatever their background - and which will link up with staff development programmes some of which are already in progress.

2. NHS Reorganisation provides an important opportunity for carrying further the progress towards better personnel management. A major circular on "Organisation for Personnel Management" is planned for issue in the Autumn, we hope that this will provide some help in suggesting flexible arrangements for making the best use of staff in setting up modern personnel departments and the right distribution of work between the different levels of authorities; but of course personnel is much more than a matter or organisation, and the circular will make this clear. There are three main lines on which we need to advance:-

a. appreciation by line managers of their role in personnel management, and understanding of how to carry out that role;

b. provision of greater expertise, i.e. properly trained staff in personnel departments;

c. the development of liaison between line managers and Personnel so that the former understand what the latter can do - and should do - for them.

3. Each of these calls for some expansion:-

On a., some line staff do not yet have an adequate concept of their role as managers of resources, let alone their responsibility towards their staff: at the worst they regard the immediate professional or technical task as paramount, and ignore both the impact it may have on other parts of the organisation, and the value and cost of the task in relation to others. There is a need to develop this awareness, and management courses should help to bring this about. There is also a need for Senior staff to become much more conscious of the importance of their proper relationship with their juniors. Managers have a major part to play in career counselling, staff appraisal and development. Although the "fliers" may be able to look after themselves they too will sometimes need to be singled out for special experience which will bring out their qualities: those who are not "fliers" are every bit as important and may need much more understanding guidance.

On b., it is necessary for the work of the modern personnel officer to be accepted as requiring as much professionalism as do other disciplines. This professional approach is however comparatively speaking new and it may be some years before all the Personnel Staff are trained to the level we expect. Chairmen can assist the development of this side of the service by ensuring that Personnel staff are properly consulted on all matters having staff implications. A lot of

useful training is already being done including specially arranged courses which over 300 staff in the existing three parts of the service will have attended before next April, and this will continue. In present circumstances it is clear that in selecting a personnel officer a great deal of weight has to be placed on his character, intellect, training and experience. A point which may be worth mentioning in this connection is that we do not view NHS Personnel work as a closed field: we want to see people who have had experience in Personnel moving into top management posts, just as some people will move out of Management into Personnel, whether for part of their career or otherwise.

On c., we must recognise that in the NHS hitherto Personnel has not been sufficiently esteemed. In the future a chief administrator must expect to consult his personnel officer about the availability of staff to undertake a required task, to ask him to prepare a forward manpower budget, to advise him on (or deal with) an industrial relations problem and to regard him as an important architect and initiator of organisational change. Clearly this will take time and will depend both upon the quality of those who fill the personnel posts, their experience and their training. Personnel Management is not something done only by Personnel Officers - line management has the final responsibility and line managers are responsible for most of the person-to-person activity - Personnel can provide an essential supporting service. This service may be partly executive, partly consultative and should in addition be able to give individuals counselling on matters not falling within

the sphere of line management.

II TRAINING

4. An important part of personnel work is education and training. Here one can distinguish three main categories. First, Vocational Training: training intended primarily to equip people for specific jobs - the whole range from professional and technical to teaching porters how to lift patients. Secondly, and complementary to this, we need management education: both linked to the work of occupational groups, and across-the-board activities covering the needs of managing a multi-professional service. For both these categories, vocational training and management training, we can and must plan ahead, decide on training patterns and training ladders, geared to fit the other personnel patterns, recruitment and promotion and so on and deploy our training staff and other training resources accordingly.

5. The third category of training is not so predictable. Management within the NHS involves frequent, or even continuous, management of change, and training can play a direct part in helping line management here. Real improvements in the service to patients or indeed in general organisation, can rarely be brought about by directives alone. Every change from the reorganisation of the NHS to, say, a new system for sterile supplies in one hospital, demands new knowledge, skills and attitudes from staff - and the attitude to the change is perhaps the most important.

6. We are all sufficiently acquainted with the NHS to know that so far most of our effort has been devoted to the first of these categories - vocational training, and this is likely to remain the biggest single element. Much of the professional training is excellent but there are a few gaps and also a few defects: insufficient co-ordination between the provision for different staff groups, between different parts of the NHS, and between those responsible for education and those responsible for service to the patient. Professionalism has been partly responsible for this situation, but our organisational and management arrangements must take some share of the respons-

ibility. There has also been a very uneven spread of resources. Indeed this does not only relate to the vocational training.

7. On the management education side, members themselves will wish to be closely involved in promoting the development of the personnel in their service. Not only is it important for time to be given to such work but even more important that they should be seen by the staff to be active in this sphere. All those who are expert in management will be aware that the top people in an enterprise should be as concerned about the management development of people as they would be about developing new systems of care or planning and erecting new buildings. The tasks in the new NHS will be great and in order to carry them out there must be available a supply of people of the right quality in the right numbers recruited and systematically trained to meet developing needs. The lack of staff who can operate effectively in modern management systems will it is well known prove a greater obstacle to meeting objectives than even shortage of money.

8. The personal involvement of members in the development of staff could take a variety of forms . We urge that in allocating your time you should give due attention to the general personnel situation in your regions. It has been the practice for many members to meet staff as they visit around their regions and that is a very useful way of finding out how people are getting on but it would be advantageous if such visits were directed say to a specific purpose such as talking to young people in a particular occupational group or to groups of staff at specified points in their careers. There are National Staff Committees which are concerned with various aspects of recruitment and career development of administrative and clerical staff and nurses and midwives currently advising the Secretaries of State for Social Services and for Wales. Some of you will know that a former Chairman of a Hospital Board, Dame Isabel Graham Bryce is the Chairman of those two interim Committees. Similar Committees for other groups of staff and a NHS Training Council will be set up so as to provide a comprehensive and co-ordinated

personnel service as was indicated in paragraph 150 of the White Paper. We will look to authorities to support the policies of such national bodies and to interpret them in constructive ways. There will for instance be staff reporting systems that will apply to large numbers of staff and which will help to identify the "flyers" and to provide the bones on which the flesh of a management training programme should be built.

9. The pay off from the considerable investment the Department and Health Authorities will be making in management education is another of the matters in which we hope members will interest themselves. There are a large number of polytechnics and some 6 or 7 universities as well as the Manchester and London Business Schools and the Staff College at Henley which provide off the job courses. We have learned a certain amount about the improvements we should seek to make in management education and put briefly they all spell out the message that the top people must interest themselves in the subject if the results in terms of improving the work of Managers are to be favourable. The National Staff Committees to which I have referred play a major role in recommending the main outlines of our endeavour in management education and members might reasonably ask whether they will have the aid of similar bodies at other levels. The subject is a complex one involving as it must a consideration of consultative machinery from the operational level through the Area and Regional levels. This is a matter on which we shall be formulating proposals and on which we shall be seeking advice. It is appropriate in considering the personnel function to recognise clearly the major points of involvement ie that authorities and their teams of officers at each level must be actively concerned in developing staff whilst the staff themselves should be a party to such endeavours.

10. There has been an increasing and welcome improvement in the attention given to the previously neglected field of the personnel function. We have urged that you maintain and promote these developments although we appreciate that funds will always be limited and the demands on resources will constantly increase. We believe however that nowadays we do not have to make a case for a share of resources for dealing with the recruitment, training and deployment of staff. We are confident that you will see that such work is considered amongst the high priorities. In all this we ask that you should ensure that the effort to develop staff is co-ordinated at regional level as it will be a national level. We hope to produce proposals that apply to more than one occupational group of staff and we look to you to promote a fully co-ordinated effort.

11. The third sort of training, training for change, is a newer idea, but there are some important recent examples in the NHS. Some of you will recall for instance the impact that is being felt in the mental handicap field from the activities of the Training Project Officers whose specific job was to see that the change of policy on patient care agreed at high level were understood and accepted by the people who were actually providing patient care at grass-roots level. A major training programme is well underway on NHS reorganisation itself: apart from the national integration courses, covering top managerial staff from all disciplines and parts of the NHS, there are the complementary Regional programmes being arranged by Joint Liaison Committees, many of which you yourselves will have been concerned with; special seminars are being arranged for consultants and general medical practitioners; and as you know the present series of short seminars for RAA and AHA members at the university and other education centres will be followed by somewhat similar seminars for your teams of officers when appointed.

12. Turning now to the future of training, the first need is to build up our rather weak resources into a good training service so that areas, regions, and the Department

can make comprehensive plans, with a proper correlation of recruitment, training, deployment and career development, both within and between staff groups, in the knowledge that training and educational resources will be adequate to meet whatever needs are identified. Chapter 15 of the White Paper on NHS Reorganisation sets out the objectives; we need to include personnel and training matters as major elements in the future planning, monitoring and other management arrangements for the NHS.

13. The divisions in the Department dealing with personnel matters have been considerably strengthened, and will be complemented by the proposed establishment of comprehensive advisory machinery, to which we have earlier referred.

14. Apart from these general aims for the future, we would like to suggest briefly to you two more specific aims. They are neither of them particularly original, but I think they are important. The first is to get away from the idea that vocational training, in particular, is something that is done to one at great length when one starts one's working life, and one is then all right to go on doing the same job for the next forty years. A few professions have instituted compulsory refresher training, e.g. every five years, for the midwives. But increasing numbers of people are going to need retraining altogether because they will not be doing the same job even in name for the whole of their careers. We want a flexible work force, not a rigid one.

15. The second aim is to make very much more use of training and related strategies to assist the introduction of change - our third category of training. "Related strategies" is rather a vague phrase, but the point is that this sort of training is very closely related to the simple need to take staff into one's confidence about change. For example, often what is needed is a conference or series of conferences which not only tells staff what the management are thinking, but equally tells management what staff are thinking and allows staff to participate in development of new plans and policies. Both the Department and NHS authorities have a lot to learn in this area.

16. One final point on joint health and social services training. In July a pilot "bridging seminar" was held, the object of which was to bring together a few of the top staff of the health and social services so that these people could get some common view of the social services in their widest sense, and begin to feel themselves as part of a single team with some common objectives.. This is only a very small beginning on what we regard as a very important subject. We hope that after reorganisation there will be a regular series of such seminars for the top people; in addition we have all to put our heads together and think what can be done similarly both for the people half-way down and for the people in the front line like general practitioners, health visitors and social workers. If training of this sort can make collaboration between the health and social services a reality, we shall have averted one of the big dangers that face us in the years ahead.

III WHAT IS THE TASK FOR THE AUTHORITIES?

1. Appoint good Personnel Officers, to head good, comprehensive personnel departments.
2. Emphasise personnel function of line managers.
3. Ensure right relations between the two.
4. Select good Whitley representatives.
5. Encourage training (including training for "change").
6. Ensure that Personnel Officers concern themselves with all grades of staff, with the promotion of consultation and communication at all levels and particularly with industrial relations problems involving ancillary and maintenance staff.
7. Foster integration of staff from LHAs and ECs.

IV WHITLEY

CENTRAL MACHINERY

17. The White Paper said that pay and conditions of service will continue to be negotiated centrally.

POWERS

18. The new Act, like the old, will empower the Secretary of State to prescribe qualifications and conditions of service for NHS staff. This is inevitable in an Exchequer financed service. Regulations will be made, similar to the present Remuneration Regulations, requiring Health Authorities to observe rates of pay approved by the Secretary of State, which for all but a few special cases will be those negotiated in the Whitley Councils. This secures consistency throughout the service.

CONSTITUTION

19. The present Whitley Councils were set up in 1948 by agreement between management and the staff organisations. (See list attached). They cover England, Wales and Scotland. Representation on the Staff Side is a matter exclusively for the Staff Sides themselves which at present comprise some 50 trade unions and staff organisations representing some 700,000 staff. Changes in the machinery can be secured effectively only by agreement with the staff interests.

20. Although the Councils will have to be reconstituted when the new management bodies are formed in the 3 countries little change is expected as regards the representation of unions and staff organisations on the Staff Sides, and therefore the Councils are likely to remain in much the same form as now.

21. We envisage continuing the present arrangement under which the Department will service the Councils and a minority of officials representing the 3 Health Departments will serve as members alongside a majority of representatives of Health Authorities who will provide the Management Side Chairmen. The officials act as the link between the Health Authority members and the Secretary of State, keeping him informed of their views and advising them of what levels of settlement the Secretary of State is prepared to approve with regard to cost and general Government pay policies. Chairmen and members will as now have ready access to the Secretary of State.

POSSIBLE CHANGES

22. There might be some advantage in having a single negotiating council dealing with all staff but

a. For such a large labour force with many different professions and occupations represented by so many organisations, this would be unmanageable. (Such a body would have to be in almost continuous session.)

b. Doctors and dentists would in any case want their pay to continue to be dealt with by the Doctors and Dentists Review Body.

c. The Staff Sides would pretty certainly want separate councils for the large diverse groups like nurses, ancillaries and administrative and clerical. (The General Council is representative of all the functional councils; it does not deal with pay and associated conditions of service - which are jealously retained by the functional council staff sides - but it deals with procedural agreements (discipline etc) and common conditions, and provides an invaluable forum for consultation on general matters affecting staff interests.)

23. Consultations are proceeding with the Staff Sides on a Departmental proposal to amalgamate the 4 Whitley Councils concerned with professional and technical staff (PTA, PTB, Pharmaceutical and Optical) into a single Council with 3 committees for scientific and technical staff, works and maintenance staff, and the therapy professions. This is the most likely area for rationalisation and reduction in the excessive number of separate pay settlements.

24. While the hope has been to reduce the number of Councils we may well, in view of insistence by the unions concerned, have to establish a new one for ambulancemen when they are transferred from local government to the NHS. But this would take in the present separate Scottish NHS ambulance service Whitley Council.

25. It has been suggested that the pay of NHS non-medical chief officers, eg those serving on management teams, should be dealt with

by an independent Review Body. This would be a matter for discussion between management and staff interests. The present position is that salaries for the new top posts will be provisional and subject to a review in 1975 the form of which has yet to be considered.

26. There is likely to be growing demand for local bargaining. This has started with the development of incentive payment schemes for ancillaries. While pay negotiation is likely to remain at national level it should be possible, given the development of an expert personnel organisation, to arrange for more delegation than has been the case hitherto.

27. The Department will be drawing up proposals for the constitution of the Whitley Councils for the new service and will need to consult representatives of the new authorities well before the appointed day.

DHSS
September 1973

WHITLEY MACHINERY (EXTRACT FROM GENERAL COUNCIL CONSTITUTION)

The Councils shall comprise -

i. A General Council.

ii. Nine functional Councils, dealing with particular groups of persons engaged in the health services, namely -

a. Administrative and Clerical

b. Ancillary Grades

c. Dental

d. Medical

e. Nurses and Midwives

f. Optical

g. Pharmaceutical

h. Professional and Technical Staffs, Group A

i. Professional and Technical Staffs, Group B.

Spare Elder

APPENDIX 6

INDUSTRIAL RELATIONS IN THE NHS

Most of P4C's activities seem to impinge on those of many other branches; but we do try to exercise restraint in the amount of paper we send round. I thought nonetheless that you would find it useful to have copies of the enclosed documents in which our attempts to improve industrial relations in the NHS are described.

The Secretary of State's speech on 12 March was the first occasion for some time that a Minister has spoken about the subject in the round.

The industrial relations training programme described in the note for the National Training Council covers 14 Districts (one in each Region) and all disciplines. It is both noteworthy and heartening that at one of the first District workshops, the chair was taken and the running made by the District Community Physician.

Ray Petch
P4C
Room 434, FRH
ex 7876

13 April 1976

Distribution:-

Mr Gedling, Mr Gough.

Under and Assistant Secretaries in P, CP, RL and RP Divisions.

Professor Reid, Dr Brothwood, Dr Tate (MED).

Miss Whitehead, Mr Adam (NUR). Mr Betts (FA3).

Mr Molineux, Mr Ratcliffe, Mr Brown, Mrs Johnson (P4C).

DEPARTMENT OF HEALTH AND SOCIAL SECURITY
FRIARS HOUSE
157-168 BLACKFRIARS ROAD
LONDON SE1 8EU
TELEPHONE 01-407 5522 ext 7876

Your reference
Our reference

7 April 1976

Dear Regional Personnel Officer

INDUSTRIAL RELATIONS

In the course of recent discussions about our industrial relations training programme, it has sometimes been said that the Department should give a clearer lead in the field of industrial relations.

As some of you know, the Secretary of State spoke on this subject on 12 March. In the course of her talk, she attempted to bring together the various initiatives that are currently under way in order to show their coherence as a package aimed at improving the industrial relations climate in the NHS.

I thought you would find it useful to have the enclosed copy of the text used by the Secretary of State on that occasion. She did not of course simply read the text out, but adapted the material to suit the occasion. She cannot therefore be quoted as having spoken any specific phrase or sentence in the text, but you may take it that the contents had her approval.

HEALTH AND SAFETY AT WORK ACT

Further to our discussion at the March meeting, I am glad to be able to tell you that the Health and Safety Commission have this week decided that the target date of 1 May which they set for issue of regulations etc about safety representatives and committees cannot now be met. It seems unlikely that the regulations etc will be issued for some months, maybe not until the autumn.

This means that staff bodies will not have any <u>statutory</u> right to appoint safety representatives on 1 May, as many have said they would do. To that extent, the heat is temporarily taken off this subject; and we will be issuing further guidance on the operation of this Act in the NHS before any further statutory requirements are laid on employing authorities.

Yours sincerely

Ray Petch

Copied to: Regional Education and Training Officers
Roger Dyson
Mervyn Message

TEXT USED BY SECRETARY OF STATE AT BLACKBURN 12 MARCH 1976

INDUSTRIAL RELATIONS IN THE NATIONAL HEALTH SERVICE

1. Introduction

When I started to think about what I would say to you this afternoon within the broad area "Industrial Relations in the Health Service" it did occur to me that in some ways it was a little presumptuous of me, after barely two years service as Secretary of State for Social Services, to be talking on this subject to an audience whose experience is bound to be so much greater than mine. However, as I thought about it I realised there were special factors which had prompted me to a particular interest in industrial relations generally and which would partly excuse my presumption today: of the eight years during which I have served as a Cabinet Minister, no less than seven have involved me directly with labour relations matters in the public services. During my 2½ years at the Ministry of Transport, I was the Minister responsible for the railways and other nationalised transport undertakings. During my two years as First Secretary of State for Employment and Productivity I saw a number of industrial disputes - both in the private and public sectors - which had as their root cause not money but the alienation of the work people caused by a lack of real involvement and participation in the decisions which affected them. And now in the last two years as Secretary of State for Social Services, I have found myself ultimately responsible for about 800,000 employees in the National Health Service and for 80,000 Civil Servants running the whole of the social security system and DHSS Headquarters branches. So you see, although my experience of industrial relations in the health service has been relatively short, my previous posts are beginning to add up to a fairly long history of involvement in industrial relations generally.

And during that time the general employment scene has certainly changed: indeed there can hardly have been a period of such dynamic change as over the past few years. There has been a wealth of new legislation aimed at improving the position of people at work, both individually and collectively, and hence leading to better industrial relations: the Health and Safety at Work Act, the Employment Protection Act, the Trade Union and Labour Relations Act, the Sex Discrimination Act, these are the main examples. But laws can only set the legal framework. The essential change is the effort represented by this legislation to give people more say in matters affecting the way they work and the conditions in which they work. I happen to believe profoundly that each and every individual matters, and can make a good and sometimes quite decisive contribution to the way his daily work is best carried out; so I am all in favour of the changes we have seen in this direction.

And in an organisation as large as the National Health Service the changing attitudes which this legal framework represents are particularly important. It is no great secret that I was not a fan of the Health Service Reorganisation scheme brought in by my predecessors. One of my objections to it was that it was too hierarchical in concept. But I do readily accept that the process of reorganisation, carried out in the climate of the legislative measures I have mentioned, has been a valuable catalyst for getting management and the unions, many of which you represent, to look afresh at

existing consultative processes. At a national level the most important of these processes is the Whitley machinery; at a local level the Joint Staff Consultative Committees.

No-one would deny that the health services have nevertheless seen an excessive amount of industrial strife over the past few years. The reasons have of course been complex, and I don't want to exhume any corpses for post mortem examination. What I would like to do is to mention briefly the various initiatives we are taking to improve the industrial relations climate in which we work.

2. Participative Management

Perhaps the most effective way of changing things for the better is to do good, if not by stealth, then at least informally. You have no doubt heard that I am keen to encourage the spread of what is called participative management. This is merely a way - albeit systematic - of encouraging staff to play a full part in the organisation of the work they are doing. As you no doubt know one of the places where it has been tried with success is not too far to the south of us - Hope Hospital in Salford. I really was very impressed by what I saw of the scheme when I visited Hope Hospital last year, and have been enthusiastic ever since to see an extension of participative management. However, this is not something which can be forced on the health service - compulsory participation really would make a nonsense of the concept. What is required is for people locally to seize the opportunities which arise, as many of them have done to improve employee participation.

Some of these opportunities arise in a rather tangential way. For instance, the introduction and maintenance of incentive bonus schemes has provided a useful impetus to discussions at a local level between management and trade unions on the detailed running of ancillary departments; and as some of you will be only too well aware, discussions on these bonus schemes have often been the first occasions ever when ancillary staff have been directly involved in the management aspects of their own work. And this is after all what participation is all about. It should enable each individual member of staff, at the grass roots, to make a contribution by harnessing his own working experience to identifying and solving problems which crop up during his working day. To yield the best results, participative management must of course be introduced into a new environment with some care. I myself hope that it will spread throughout the service, and I am considering issuing a guidance circular on the subject in the near future which will, I hope, help it on its way.

3. Industrial Democracy

On a more formal level you will know of the action we are taking to get staff representatives elected to Health Authorities, and have probably seen the consultative paper we have issued on democracy in the NHS. Some of you may be thinking that our consultative paper does not go far enough and that more places should be allocated to staff representatives. Certainly I believe that those who work in the NHS have a valuable contribution to make to its management and that is why I want to see them contributing as members of health authorities. But I think you will all agree that there are others who have a contribution to make as well. The local community, for whom health services are provided, has a right to be involved in the management of their own services. That is why we are increasing the proportion of health authority members drawn from local authorities to one third since they are the elected representatives of the community. In addition, we need to leave room on health authorities for other people who because of their particular experience or knowledge have something special to offer the health service.

You should also remember that industrial democracy in the public sector is still in its infancy and that we in the health service are actually ahead of the field. You may indeed have noted the statement in the House of Commons on 11 February that the Government's studies into the introduction of industrial democracy in the public sector would not cover the NHS since we were already taking action. I am pleased that we have been able to take a lead like this but I would be the first to say that we should not allow ourselves to become complacent because of our early start. There are problems which we shall encounter in extending employee participation and industrial democracy in the health service and we shall have to learn to deal with these. Indeed some difficulties are already apparent and there are three in particular which I think we must recognise and acknowledge. First we must recognise the dilemmas which must be faced over employee participation and industrial democracy throughout the public and private sectors: the fear that some of you as employee representatives will have that if you participate too fully you may end up representing the interests of management to the work people instead of the other way round; and the concern that employee representatives may be "sucked in" and tarred with the brush of management decisions not withstanding their disagreement with them. There is a further dilemma in this area which is specific to the public sector, including the health service, and this is the degree to which employee participation may conflict with the general democratic will as expressed through Parliament. We must acknowledge that a degree of conflict between the interests of the work people and the wider interest of the service may well exist but that no system can work which seeks to emasculate and suffocate particular interests which are represented within it.

Secondly, and following from this, it must be accepted that a trade unionist once elected to a representative body will not sever his links with those who put him there. In other words it must be understood that employee participation can only operate successfully if it is seen not as an alternative to or a negation of collective bargaining but as an extension and a strengthening of it.

Thirdly, it must be shown that a crucial input into decisions in the health service is the experience and opinions of the staff within the service. And that whilst Parliament, Ministers and Authorities in the ultimate analysis have the final word, the closer to the practical point of decision that this input can be made the more effective it is bound to be and, in my view, the better quality the final decision is likely to be.

4. Collective Bargaining

I mentioned just now that employee participation should be seen as an extension of collective bargaining. In the NHS, collective bargaining in its formal sense means of course the Whitley system. This has served us fairly well over the years but like any other hard-worked machine it needs overhaul. You will know that in April last year I appointed Dr W E J McCarthy, now Lord McCarthy of Headington, as a part-time adviser to the Department of Health and Social Security on Industrial Relations. He is engaged on a review of the workings of the NHS Whitley machinery and will report directly to me. In his

investigation so far he has met members of Management Sides, chairmen of Health Authorities and representatives of NHS management at all levels from Region to Sector. He has invited written comments from all the staff organisations represented in Whitley, most of whom have now replied. He has also met representatives of these organisations, which of course included members of Staff Sides of Whitley Councils. Lord McCarthy has now virtually completed the collection of views and I expect him to report by the summer.

Lord McCarthy's terms of reference were to carry out a review and this does not necessarily mean that there will be a wholesale reform of the Whitley system. At this stage I can only repeat what I have said on a number of occasions, that is that I do not see it as my function as Secretary of State to impose any changes in this field. I wish to hear the views of all those involved and if it becomes clear that changes to the system are necessary I feel very strongly that these should be initiated from below and not imposed from above.

5. Staff Consultation

There has of course always been machinery for consulting staff in the NHS before major policy changes were introduced. However, this machinery has not always been sufficiently flexible or extensive and I am glad to see that the General Whitley Council is currently negotiating an agreement for new joint staff consultative machinery, and that these negotiations are in their final stages. One of the main criticisms of the existing agreement has been its rigidity. I expect the new agreement to set out the basic principles and to make the establishment of a joint staff consultative committee mandatory at certain levels, but otherwise to leave the details to be settled between management and staff interests locally. When this agreement has been made, I hope that shop stewards will play a full part in making it really work.

6. Facilities for Staff Organisations

Another area in which the General Whitley Council has recently been negotiating is in providing facilities for staff organisations. Proper facilities for Trade Unions locally are beneficial both to management and shop stewards. Both the Ancillary Staffs Council and the Ambulancemen's Council have had such an agreement for some time for staff within their purview. For other staff there has been for some years a rather limited General Whitley Council agreement on Facilities for Staff Organisations in Hospitals. Amongst its limitations it left the granting of facilities for posting notices and holding meetings entirely within the discretion of the authorities. In the changing industrial relations climate we recognised that this agreement was quite inadequate and that a more detailed agreement was required, setting out basic facilities which should be extended to staff representatives throughout the NHS. The General Whitley Council has therefore recently concluded such an agreement covering the other groups of staff within the National Health Service and full details of the agreement will be issued shortly. I hope that this too will facilitate more effective local consultation.

7. The Personnel Function

I have been talking to you this afternoon about the role you as trades unionists can play in improving the working of the health service - and ultimately the service to patients - and about the initiatives we have taken centrally in the industrial relations field. Before I sit down I would like to turn your attention for a few minutes to personnel management and the role of the personnel officer. Whatever we do at the centre, the improvement of industrial relations in the NHS ultimately depends on the effectiveness of the personnel function in the field. I have spoken frankly in the past about some of the faults of reorganisation but I am sure that it was right to use this opportunity to introduce a more professional approach towards personnel management. The personnel discipline was very slow to develop in the National Health Service partly because the Service was not ready for it in the 1960s and the Government and, in particular, my Department could not impose something like a personnel function on a Service which was not ready for it. There were far too many separate managements in the three arms of the Service: the professions on the whole saw themselves as self-regulating and the Service had a tradition of dedication so that on the surface it seemed that the industrial relations climate was fair. In the 1970s, however, the NHS realised that it needed to put its industrial relations in order and management needed professional personnel managers to assist in this, to help in career development, and to help individual members of staff to deal with increasingly complicated rules and regulations, most of which were to their benefit but still needed interpretation.

I am glad to see some Personnel Officers here today. Those Personnel Officers who are new to the service haven't all yet found their feet but they are trying hard. I hope you will help them, since I am sure that an effective personnel function can help unions as well as managers in smoothing over the difficulties that are bound to arise from time to time - as well as engendering more trust and co-operation all round. That really is what industrial relations are all about; and nowhere more so than in the health service where we are basically dependent on each other in carrying out our task of delivering health care to those who need it.

8. Conclusion

Well, that is what we are up to. I hope you feel we are on the right lines. I have covered a wide field and I hope you won't expect me to answer questions of detail on all the things I have mentioned. But on general points I have dealt with, or any others that seem to you relevant, I should be glad to hear your views and try to answer your questions.

IN CONFIDENCE

NATIONAL TRAINING COUNCIL FOR THE NATIONAL HEALTH SERVICE

INDUSTRIAL RELATIONS TRAINING

1. At their January meeting, the Council considered at some length the Department's plans for industrial relations training as described in NTC 76/3 and elaborated orally at the meeting. The Department undertook to consider the many interesting points made in the discussion, and to report on the uni-disciplinary workshops at the Council's May meeting.

The Conceptual Approach and its Effects

2. The training programme which the Department has set in train can be briefly described as being aimed at encouraging NHS management at operational level to develop a more cohesive approach to their industrial relations responsibilities, so that they may be the better able to engage in constructive dialogue with staff representatives.

3. The programme is directed at District level, and some doubt was expressed at the Council's January meeting as to whether this was the right, or sufficient, level. As the programme unfolds, we are increasingly convinced that this judgement was sound. To quote from a contribution made at the Manchester seminar for Regional Administrators and Senior Managers in October 1975, "the DMTs are the executive line managers and should be given as free a hand as possible to get on with the job, providing they are given clear policy guidelines within which to work". By focussing this training programme on the DMTs and their immediate colleagues, we are following this principle. The training is aimed at all disciplines at this level, and we are confident that as its recipients together develop a cohesive approach to industrial relations in their District, that approach will rapidly percolate to management at supervisory level in the District.

4. The training material emphasises that Districts must work out their policies "within the appropriate national, Regional and Area framework" and Districts are therefore asking these other tiers to specify what that framework is. The latter in turn are finding that they themselves need as a matter of priority to

determine more clearly than before their own respective roles and are thus having to face a number of awkward questions. The result can only be beneficial in the organisational development of the NHS, particularly in relation to the personnel function.

The Uni-disciplinary Courses

5. The eight uni-disciplinary courses which were reported at the Council's January meeting have been provisionally evaluated. At this stage evaluation has been based largely on extensive questionnaires completed by members at the end of each course, and it therefore relies mainly on their own perceptions.

6. On the basis of these perceptions, all the courses can be judged to have been successful. The uni-disciplinary approach was thought conducive to sharing of common problems, and the participative nature of the training given to have led to a high degree of involvement. Members would however have liked more formal inputs about the industrial relations framework within which they had to operate (see para 4 above) and more specific training in negotiating skills. Virtually all members found the courses highly relevant to their existing management roles and even more relevant to what they perceived their future roles to be. This change of role perception (most notable in the case of the medical members) was itself an extremely valuable outcome of the courses.

7. The value of these courses will however best be tested by reference to members' effectiveness in their "back-home" situations. In particular, the degree to which the courses enabled them to contribute to the District workshop will be crucial. As part of the evaluation process, a further questionnaire will therefore be issued in the early summer.

8. On present evidence, the uni-disciplinary courses may therefore be judged to have been a qualified success. The training material used has been preserved and, in the light of experience, will be modified into a training package for wider use as the programme is developed.

The District Workshops

9. All 14 Districts had by the end of March made plans to hold their District workshops and some had completed the preliminary stages. Some schemes are more ambitious than others and all vary in timing and method. The two course tutors are each advising 7 Districts, for which the Department is funding one day per District. The Districts are being encouraged to keep in close touch with Area, Region and the Department; and representatives of these three tiers are being invited to attend various workshops

10. Arrangements are being made for the District workshops to be systematically evaluated. Although they are proceeding in a variety of ways, each District has been asked to report:-

a. what objectives they have themselves set for their workshop;

b. what meetings they have in relation to the workshop and what level and number of managers attend each of these activities;

c. what the workshops achieve in terms of decisions for implementation.

The reports are requested by 1 July and the course tutors will assist in their preparation. The date is somewhat arbitrary, since there can be no finality in a programme designed to facilitate the ongoing management task. But a common reporting date will enable us to take stock of the effectiveness of the programme at that time and to plan for further developments.

Future Developments

11. The Department's present efforts are dedicated towards ensuring, so far as we are able, that the pilot programme in the 14 Districts will:-

a. be enabled to run on to July with the maximum possible assistance and encouragement from the centre; and

b. be carefully documented with a view to its wider propagation.

Thereafter, we will be able to plan how best to proceed in relation to further development of the programme.

12. The programme has however already identified additional training needs in the industrial relations field (see para 4 above). We are currently considering how these needs might best be met, and will report on our intentions at the Council's May meeting. We will also on that occasion give an up-to-date report on the progress of the pilot programme and discuss our tentative views as to how the beneficial effects of the programme might best be disseminated to other Districts.

Annexure 11

APPENDIX 7

Area Team

SHT.

(SH & SET 6 Admin A.T on 11 Oct

Y SWYDDFA GYMREIG
WELSH OFFICE

Pearl Assurance House Greyfriars Road Cardiff CF1 3RT
Telephone Cardiff (0222) 44151 ext 404

Mr A M Evans
Area Administrator
South Glamorgan AHA
Temple of Peace & Health
Cathays Park
CARDIFF

Your reference

Our reference

Date

21 September 1977

SOUTH GLAMORGAN HEALTH AUTHORITY (T)
22 SEP 1977

Dear Sir

INDUSTRIAL RELATIONS TRAINING

Last month the National Training Council circulated a paper in England at regional level seeking views on proposals for industrial relations training. I have obtained a copy of that paper and have just been asked by the National Training Council to circulate it to area health authorities in Wales for comment.

Accordingly I enclose 5 copies of the National Training Council paper so that you may obtain the comments of your colleagues on the Area Team and of your Area Personnel Officer. The two main proposals to emerge from the National Training Council working group on industrial relations training are that there should be a series of centrally organised and funded courses and that a national training manual should be produced.

The next meeting of the Training Council will take place on 17 October. It would therefore be helpful to have comments on the paper as soon as possible. I am sorry that we have been faced with this very short timescale for comments.

Yours faithfully

John Lewis

J C LEWIS

RA 77/25
RNO 7/9/77
RHAT 77/19
RMO

IN CONFIDENCE

NATIONAL TRAINING COUNCIL FOR THE NATIONAL HEALTH SERVICE

INDUSTRIAL RELATIONS TRAINING

Introduction

1. The National Training Council has since its inception attached prime importance to industrial relations training in the National Health Service. Because of the late emergence of the personnel function, the scope for the development of such training is very great. On the other hand, shortage of money is aggravating the difficulties of the situation, with double effect. By increasing the strains upon staff in all disciplines at all levels, it makes good industrial relations even more difficult to achieve. At the same time, by inhibiting the deployment of resources, it limits ability to institute training. The Training Council has therefore given a lot of attention to this subject, at first in plenary session but recently through a Working Group, led by the Vice-Chairman of the Council, Lady McCarthy.

2. The Group's task has been to examine the industrial relations training being undertaken in the National Health Service and to recommend possible future activities. After nine meetings, twenty visits and two consultations with representatives of the personnel function, a first report has been presented by the Group to the Council and accepted as a proper basis for further action. The next step is, through the present document and discussion of it, to extend the process of consultation into wider fields. The Working Group's ultimate aim is to produce firm recommendations to the Training Council of immediate action on training within the framework of co-ordinated plans for the future.

Present Industrial Relations Training

3. Three main kinds of activity are discernible. Regions and Wales undertake training for industrial relations as part of their general training programmes; the National Management Education Centres teach the subject as part of their management training courses; and over some two years a national pilot scheme, funded by DHSS, has been running in fourteen Districts, one per Region. Brief summaries of the Working Group's findings in regard to each kind of activity are given in the following paragraphs.

Training in Regions

4. Regions vary in the resources which they put into training of this kind. Some of them have prepared comprehensive training packages for use on courses throughout the Region. Others rely heavily on outside assistance from academic sources. All of them have mounted some training on employment legislation in general and the Health and Safety at Work Act in particular.

5. Points of detail are:

5.1. Several Regions have found it necessary to produce training handbooks, based on explanations of recent legislation, in a form that will be useful to both specialists and line managers. Although content varies somewhat, material on legislation is common to all. To people in the Regions concerned who have invested considerable time and money in the production of such material, a waste of resources seems to have occurred. The point has been made frequently that provision of a national handbook embodying the common material would have saved valuable time and money and can yet do so.

5.2. Some Regions have specialised in forms of training and developed "libraries" of documents and information about them. Because of inadequate communications, however, the existence and availability to others of these specialised collections is relatively unknown. Here again, therefore, waste of resources may be occurring.

5.3. It has been encouraging to learn that a quarterly news-sheet for personnel specialists has been launched, which is to carry information like this, among other items. It would, however, be useful if more generalised and deliberate arrangements could be made for Regions to become aware of what help is obtainable from others. Such resources as are available for training should not be used for the production of material which already exists elsewhere.

aining in Wales

In Wales, training is primarily an AHA responsibility and reflects local eds and opportunities. Generally, the emphasis is upon employment law, the bject being taught mainly by College and Polytechnic lecturers on induction d management courses and in specialised seminars; but the national Whitley amwork and local procedures are also covered, with practical negotiating and levance - handling exercises.

ional Management Education Centres

Five centres are wholly or partly funded by DHSS, at the Universities of rmingham, Leeds and Manchester, at Leicester Polytechnic and at the King's d College. Centres' main teaching work is on the senior management development rses, administrators' development courses and National Administrative Training eme courses. The industrial relations content of these courses extends over e four or five days. It does not vary greatly. Most attention seems to be en to the relavent legislation, though with considerable emphasis also on exercises negotiating skills.

Leeds and Leicester specialise in industrial relations and by virtue of that do a great deal of the training in the subject provided by their "home" onal Authorities, respectively Yorkshire and Trent. Leicester is used also by f organisations for schools and seminars. Leeds is currently designing training ages on particular aspects of industrial relations. Birmingham was joint sor with Keele University of the National Pilot Scheme.

nal Pilot Scheme

In the first phase of this scheme, eight uni-disciplinary sessions of industrial tions training for specified senior managers from one District in each of the ns were held at the Universities of Birmingham and Keele. The objective was tivate and prepare the managers for local workshops on the subject. After initial training, multi-disciplinary workshops would proceed with the develop- of policies, procedures and training for good industrial relations in their icts. From this activity, a "cascade effect" would, hopefully, carry the its into other Districts of the Regions and in time throughout the Service.

For the Working Group, fourteen visits have been paid to District Workshops, one per District involved in the Pilot Scheme, together with six visits to d activities.

In the Group's view, the Pilot Scheme as conceived and executed has been ly successful in motivating participants and raising perceptions. Through re of ignorance and lack of expertise, it has whetted appetites and prepared for prompt and vigorous follow-through. Such action began in the Autumn 6, when DHSS and the MSC(N&M) mounted three courses and a workshop for personnel rs at Area level, involving 46 Areas in England and Wales.

12. In the course of visits, a fundamental criticism met has been that the opportunity to provide the Service with a strong lead through a national training framework with scope for local variations has been lost. For lack of a framework, some people have professed to feel isolated and exposed to all the uncertainties of self help. To level a criticism like this at the Pilot Scheme is misconceived, since its remit was not designed to provide such a framework, but the point seems valid as a comment on the loss of an opportunity at the centre. The Working Group regards the loss as material and would like to see it remedied quickly. The Pilot Scheme will have provided experience from which a national training framework can be developed. Meanwhile the visits to workshops have brought out the inescapability of differences between the various Districts in background, attitudes and styles and the consequent importance of scope within a framework for local variations.

13. As to the "cascade effect", success within a District can be seen to depend on the presence there of interested people with strong personalities yet measures of tact. Again, some impressions have been gained during visits to workshops and related activities of people regarding themselves as having little or nothing to learn, of being contributors rather than beneficiaries - a recipe for trouble. In wider fields, factors inhibiting to success may be: reluctance to accept others as sufficiently knowledgeable when their knowledge is of recent origin; a lack of people with teaching experience; and a dependence on the vagaries of relationships between Districts and with Areas and Regions. Despite all this, however, serious and substantial hopes of success for the "cascade effect" are entertained by the Working Group.

Conclusions

14. The Working Group considers that a training phase should now follow the Pilot Scheme, based on a national framework with scope for local variations and having particular reference to the extension of knowledge and the development of skills. The personnel function makes an obvious choice for first attention, since it is the prime NHS source of expertise on the subject for managers generally; also because personnel officers have a professional concern to improve the quality of the management of industrial relations: though a rapid build-up of knowledge and skills seems to be required over the Service as a whole. The Working Group has therefore framed proposals for training which, as indicated above, have been put to the test of consultation with representative personnel staff and modified in the light of comments made. These proposals are meant to complement existing activities, without in the least replacing or restricting them, and to leave full scope for initiatives by others.

Proposals for Training

15. For the immediate future, it is proposed that two or three courses be centrally organised and funded, each of two weeks' duration and each for about 30 personnel staff from all organisational levels and disciplines. These courses would aim: mainly to consolidate the knowledge and develop the skills needed to carry out the current and future roles of personnel staff in the field of industrial relations; but also to help participants subsequently to impart knowledge to and develop skills in other staff. A basic familiarity would be assumed with employment legislation, relevant trade union history, unions present organisational patterns, the Whitley structure and pay systems, so that attention might be concentrated on areas of current and prospective development and change and deeper levels of understanding.

16. The knowledge elements of the proposed course would cover:

16.1. employment legislation and case law;

16.2. development of the personnel function in industry and the NHS.

16.3. development of trade unions and professional associations, particularly in relation to the NHS;

16.4. internal organisation of trade unions and professional associations operating within the NHS; and the roles, responsibilities and duties of their officers at the various levels;

16.5. the impact of organised labour on management control;

16.6. organisation of the Whitley structure;

16.7. pay systems: available methods; their relevance to the NHS; advantages and disadvantages; points about negotiations;

16.8. industrial relations implications of manpower planning;

16.9. the industrial relations role of the personnel officer in the NHS.

17. On skills, the syllabus would take in:

17.1. the establishment of policies acceptable to both sides, notably in regard to planning, consultation, participation, change, motivation and communication;

17.2.processes of negotiation, with special reference to pay and productivity agreements and their implementation;

17.3. grievance and disciplinary procedures from initial stages to preparation for and appearance before Industrial Tribunals;

17.4. conciliation procedures;

17.5. the handling of conflict.

The number of courses on these lines should progressively increase, beginning h two or three at Harrogate, say and subject to evaluation spreading first National Education Centres and thereafter to suitable Regional venues. Meanle, those who have attended earlier courses should be encouraged to disseminate benefits among colleagues, particularly in line management with a view to reasing awareness of and attention to the industrial relations implications everyday activities. To assist in the latter process, a training manual would required, for use by personnel staff and others.

onal Training Manual

Having regard to points made above, in paragraph 5, a national publication s to be indicated, which Regional Personnel Officers and the Working Group

might undertake to develop, as a joint project. It may be early to go into extended detail and yet an immediate need for something of the kind can be seen. A loose-leaf binder and a service for up-dating and developing content would be the required vehicles. Immediate content should be factually informative and items for inclusion might be: teaching documents from the proposed courses; Whitley agreements; codes of practice; model procedures; rules on sickness; recognition of unions; rights and responsibilities of shop stewards; guidance on handling of grievances; breaches of discipline and disputes; ramifications of picketing; notes on cases of major significance; and select bibliographies. Upon such beginnings processes of development could build.

A Training Framework

20. Consideration has been given also to how to set the proposed courses into a wider framework, for carrying such training forward, with particular reference to training for line managers and the following questions have been identified for examination in detail:

20.1. whether to work from the bottom upwards or vice versa;

20.2. on what groups to begin: for instance, on administrators as key people to help in the meeting of needs; on nursing staff, as working in a developing area of industrial relations and as having a great disparity of training needs; on para-medical staff; on managers of ancillary and other support services; on particular units; on district management teams; on multi-disciplinary groups; on senior managers;

20.3. how to practise devolution in this context.

The Present Need

21. Against the background of paragraphs 1 to 13, the rest of this paper sets out training proposals and thoughts on a strategic approach which have been discussed successively with Regional Personnel Officers and a seminar of personnel staff drawn from all levels of the Service and including a doctor and nurses. Reactions have been favourable, though suggestions for improvement have been made, which are now included and gratefully acknowledged. In presenting this paper to groups and interests outside the personnel function, their views are invited and will be welcomed. The aim is to make recommendations to the Training Council at their next meeting on 17th October that will enjoy general support and that can lead to the opening of a new phase in training for industrial relations before the end of the present financial year.

P4B

August 1977

M/N196/32

NRO/78/36
RETO 78/8
WCIRT 78/16

APPENDIX 8

INDUSTRIAL RELATIONS TRAINING:
PLANS FOR FURTHER COURSES AND DEVELOPMENTS

1. As a result of the evaluations made of the first two industrial relations courses run under the aegis of the National Training Council, the structure of the third course was substantially modified as indicated in the course programme attached as Annex A. As a result of this, and also the way in which the course membership "gelled", the third course, which took place at Harrogate from 5 to 16 June, appears to have been very successful. The course size (29) was however still generally thought to have been excessive. A full evaluation report is being prepared and will follow in due course.

2. Attached as Annex B are analyses of :-

a) the third course membership;

b) the membership of the first three courses by function and grade;

c) the membership of the first three courses by county and region.

3. It will be seen from these analyses that the first three courses have together covered a total of 87 officers, 4 of whom were not "personnel specialists". The overall population of personnel specialists in England and Wales - which is of course in any event always turning over to some extent - is of the order of 1,500. We hope that RETOs and RPOs will give some time at their July meetings to the question of the extent to and methods by which this type of training for personnel specialists should be continued. The subject will then be discussed further by the National Training Council's Working Group on 21 July.

4. Present firm plans are that three further courses should be mounted at Harrogate during this coming winter, but with a reduced membership of 20 officers on each course. Mr Stuart Dimmock will again be the Course Director for these three courses. It might be worthwhile for one (different) RPO to be closely associated with each course as a member of the tutorial team.

5. A draft health notice announcing these three courses is attached as Annex C. Given that pre-selection interviews on a centralised basis are not practicable - and in principle this would clearly be desirable in order to ensure a satisfactory "mix" on each course - it is hoped that RPOs/RETOs will pay special attention to the selection of nominees from each region. It is not considered desirable to restrict nominations by reference to grading level, since this might - on the evidence of the first three courses - exclude some officers who would in all other respects be admirable members of these courses.

6. Thereafter, it is intended to mount three further courses - again of 20 members each - at Harrogate in the spring of 1979. Precise arrangements for the direction of these courses have not yet been determined: but again it might be useful for one (different) RPO to be associated with each course.

7. After that, consideration is being given to the following three options for continued training of personnel specialists, which are not mutually exclusive :-

a) continuing with a regular (monthly, bi-monthly, or quarterly) series of centralised courses at Harrogate;

b) sponsoring courses at each National Education Centre, each Centre to cover it's customary consortium of regions;

c) encouraging the mounting of similar courses by individual regions.

Comments from RETOs and RPOs on these options will be welcome at the July meetings with the Department.

8. Having established the necessary momentum on training for personnel specialists, the National Training Council's Working Group is now turning its attention to the question of industrial relations training for line managers. The Group has identified the following three levels of line management, each of which probably requires a different approach.

a) Health Authority members and senior officers;

b) middle managers;

c) first-line supervisors.

The preliminary views of RETOs and RPOs on these questions will also be very helpful at this stage.

9. In order to facilitate further informed consideration of this subject, the Working Group with the Department are arranging a seminar to take place on Friday 8 September. The precise membership of this seminar has not been determined; but it is likely to include 4 representatives from each of the three courses that have already been held for personnel specialists.

DHSS/P4C July 1978

NATIONAL TRAINING COUNCIL FOR THE NATIONAL HEALTH SERVICE

INDUSTRIAL RELATIONS FOR PERSONNEL SPECIALISTS

to be held at
NHS Training and Studies Centre, The White Hart, Harrogate
from
5 to 16 June 1978 (inc)

COURSE PROGRAMME

			Speakers
Monday 5 June			
Afternoon :	1500	Assembly and tea	
	1515	Introduction by the Rt. Hon. David Ennals, M.P., Secretary of State for Social Services	
	1545	Course introductions, objectives and validation	
Evening :	1930	Industrial Relations and the Personnel Function	W.L. Moore
Tuesday 6 June			
Morning :	0915	The Professional Associations - Issues and Prospects	R.F. Dyson
Afternoon :	1400	Manpower Planning and its IR implications	R.Petch A. Anstey
		Plenary and seminar work	
	1730	Briefing for Industrial Tribunal Exercise	Course Tutors
Wednesday 7 June			
Morning :	0915	Time-off and Facilities/Health and Safety Representation	Course Tutors H.C.T. Fawcett
		Plenary and seminar work examining the principles and forms of local arrangements within the context of the proposed national agreements.	
Afternoon :	1400	Joint Negotiations I	Course Tutors
		Negotiating exercise and evaluation of approaches towards negotiation.	
Thursday 8 June			
All day :	0915 - 1730	Employment Legislation Plenary and seminar work examining the implications of recent case law on unfair dismissals.	S.D. Anderman
Evening :	1930	Trade Union Approaches to the Public Sector	E.Sheehan

Friday 9 June			
Morning and Afternoon:	0915 - 1100	Lessons from the investigation of trade union workplace organisation in industry	R. Undy
	1530	Workplace organisation and Management Policy in the NHS Plenary and seminar work examining local consultation/negotiation structures, the bargaining area, and management policy.	R. Undy and Course Tutors
	1600	Trade Union Training and Education A review of recent developments in trade union education and its implications for the NHS	
	1700	Briefing for Joint Negotiations II and III	Course Tutors
Evening :		FREE	
Saturday 10 June		FREE	
Sunday 11 June			
Morning :	0930	Trade Unions Plenary and seminar work	Lord McCarthy
Afternoon :	1400	Joint Negotiations II Exercise and analysis of negotiating practice	Course Tutors
Monday 12 June			
Morning :	0915	Negotiating Skills Plenary and seminar work to formulate a framework for negotiation.	Course Tutors
	1100	Union Membership Agreements The circumstances and form of the Northants UMA facilitating agreement	P. Marsh
Afternoon :	1400 - 1530 (approx)	* Productivity Bargaining A re-cap on the principles and methods of work measurement schemes	M. Barnwell
	1600	Joint Negotiations II - Devising Joint Agreements Preparation in seminar groups	Course Tutors

* (The session on Productivity Bargaining is optional)

Tuesday 13 June

All day	0915 -1800	Joint Negotiations III - Negotiating Joint Agreements Negotiating exercise	Course Tutors K. Barnard F. Burchill S. Harrison P. Johnson

Wednesday 14 June

Morning	0915	Industrial Relations Strategies Plenary and seminar work	Course Tutors
Afternoon	1400	Industrial Tribunal Exercise - Preparation	

Thursday 15 June

All day	0915 - 1900	Industrial Tribunal Exercise Preparation and presentation of a case	J. Angel
		Mock Industrial Tribunal	I.T. Chairmen J. Angel H. Chapman J. Doe
Evening		FREE	

Friday 16 June

Morning	0915	Industrial Tribunal Exercise Tribunal decision and evaluation of course members' presentation and preparation of cases.
	1100	Course evaluation
	1230	COURSE ENDS

Please Note

Normal mealtimes :

Breakfast	0800 - 0845
Lunch	1230 - 1400
Dinner	1815 - 1915

Mid Weekend :

Breakfast	0830	Self Service
Lunch	1230	
High Tea	1700	

ANNEX B

ANALYSIS OF COURSE MEMBERSHIP (29)

AGE GROUP:	20-30	30-40	40-50	50-60
	3	12	11	3

NHS LEVEL:	DISTRICT	AREA	REGION	OTHER
	9	14	5	1

POSITION:			
	RN(P)		1
	APO	(Scales 29 and 27)	5
	Assistant APO	(Scales 18-9)	4
	AN(P)		2
	DPO	(Scales 20-9)	4
	Assistant DPO	(Scales 9-4)	2
	Nursing Officers		4
	Doctor		1
	Other Personnel by Scale:-		
	23		2
	18		1
	14		1
	9		1
	SEO		1

TIME IN JOB:	1 year or less	1-2 years	2-3 years	Longer
	7	4	6	12

MAIN PROFESSIONAL QUALIFICATIONS:

Student for IPM Pt 1	1
MIPM	6
IMS	1
Pg Diploma	4
IHSA	4
AITO	1
AHA	2
FHA	1
AMBIM	1
FIPMSOM	1
MITO	1
DSA	1

MALES - 23 FEMALES - 6

INDUSTRIAL RELATIONS COURSES 1-3

ANALYSIS OF OVERALL MEMBERSHIP BY FUNCTION AND GRADE

Personnel Officers:-	RPO	1	
	APO (scales 29-27)	19	
	DPO (scales 18-9)	16	
Other	Scale 27	1	
	Scale 23	1	
	Scale 18	3	
	Scale 14	5	
	Scale 9	9	
	Scale 4	2	
Training Officers:-	RETO	1	(plus 1 included above as Acting RPO)
	AETO	2	
Other	Scale 23	1	
	Scale 18	1	
	Scale 4	2	
Nursing Officers:-	RN(P)	2	
	AN(P)	10	
	DN(P)	1	
	Other (largely personnel specialists)	5	
Doctors:-		1	
General Administrators:-	Scales 27-14	4	
TOTAL		87	

INDUSTRIAL RELATIONS COURSES 1 - 3

FURTHER ANALYSIS OF COURSE MEMBERSHIPS

	COURSE 1	COURSE 2	COURSE 3	TOTALS
ENGLAND				
NORTHERN	1	1	2	4
YORKS	2	1	2	5
TRENT	3	1	2	6
EAST ANGLIA	0	2	1	3
N E THAMES	2	2	2	6
S E THAMES	2	2	3	7
S W THAMES	0	2	2	4
N W THAMES	4	2	1	7
WESSEX	1	2	3	6
S WESTERN	3	1	-	4
OXFORD	1	2	3	6
W MIDLANDS	2	2	2	6
N WESTERN	2	3	1	6
MERSEY	3	1	2	6
BGs etc	2	1	1	4
SCOTLAND	1	1	1	3
WALES	2	1	1	4
GRAND TOTALS	31	27	29	87

ANNEX C

DRAFT HEALTH NOTICE 10 July 1978 HN(78)

TO: Regional Health Authorities) for action
Boards of Governors)

Area Health Authorities) for information
Community Health Councils)

PERSONNEL

STAFF TRAINING

CENTRALLY - ORGANISED COURSES - INDUSTRIAL RELATIONS TRAINING

Summary

This Notice gives information about and requests nominations (from Regional Health Authorities and Boards of Governors) for three centrally organised courses on industrial relations.

Present Training Plans

1. HN(77)193 gave information about three courses on industrial relations; it is now the intention to mount another three in the Winter of 1978-79. Please note that the dates are not identical with those given in HM(78)30.

2. The courses, developed by a Working Group of the National Training Council in collaboration with the Department and after extensive consultation with representatives of the NHS, will be continuous (ie without a weekend break) and will be mounted on a residential basis as follows:

Location	Inclusive dates
NHS Training and Studies Centre, Harrogate.	lunch 20 November - lunch 1 December 1978
	lunch 10 December - lunch 21 December 1978
	lunch 8 January - lunch 19 January 1979

The membership of each course will be restricted to about 20. Taking the three courses together, four places are intended for each English region.

3. The course has been designed for staff who are predominantly engaged on industrial relations duties. Members will be assumed to have a basic familiarity with employment legislation, the Whitley system, the history and organisation of trade unions and professional associations and with pay systems and manpower planning. It is therefore anticipated that nominations will generally be confined to senior staff working in Personnel Departments and to Specialists in Community Medicine and Nurses engaged on personnel duties.

4. The course will provide advanced tuition and training in subjects relevant to the conduct of industrial relations in the NHS and will be participative in nature. The main subjects to be covered will be:-

a) the role of the personnel specialist;
b) the structure and operation of staff organisations;
c) employment legislation;
d) manpower planning;
e) workplace organisation and management regulation;
f) union membership agreements and disputes procedures;
g) grievance and disciplinary procedures;
h) negotiation skills and grievance handling;
i) industrial tribunals.

5. The Course Director will be Mr Stuart Dimmock of the Nuffield Centre for Health Service Studies at the University of Leeds. Speakers and tutors will be drawn widely from other national Management Education Centres, the industrial relations faculties of other universities, the NHS and the Department.

FINANCE

6. The course fee, which covers tuition costs and the costs of accommodation and meals, will be met by the Department. STM 47/70 indicates directly or by cross reference that employing authorities have discretion to grant paid leave and pay travelling expenses in respect of those who attend. Incidental expenses allowance may be paid in accordance with HN(77)14.

FURTHER DEVELOPMENT

7. These three courses will be carefully monitored and evaluated by the National Training Council's Working Group. In the light of experience gained from these courses and those already mounted , the Working Group will develop further proposals aimed at increasing the level of industrial relations expertise within the NHS. These proposals are likely to include:

a) the production of a training manual based on the material generated during the initial specialist courses;
b) the mounting of further specialist courses;
c) the industrial relations training needs of Health Authority members and line managers at all levels.

ACTION

8. In order that the Course Director may ensure that each of the three courses covers a suitable mix of staff, by reference to the various levels of the NHS and the different disciplines likely to be nominated as well as to age and experience, each RHA is invited to nominate a pool of 8 officers for attendance at the courses. Additionally, one nomination may be submitted by each Board of Governors. Nominations will only be accepted from Regional Health Authorities and Boards of Governors. The selection of membership for each course will be made and notified as soon as possible after the closing date for nominations.

9. Nominations as above should be sent in the form of the Appendix to this Notice no later than 29 September 1978 to Miss K Miller at the address below.

From

Personnel Division 4C
Friars House
157-168 Blackfriars Road
London SE1 8EU

01-703 6380 Ext 4156 N/I49/65

Further copies of this Notice may be obtained (by written request wherever possible, please) from DHSS Store, Scholefield Mill, Brunswick Street, Nelson, Lancs BB9 OHU. Tel Nelson (0282) 62411/2 ext 17.

APPENDIX TO
HN(78)

NOMINATION FOR INDUSTRIAL RELATIONS COURSES

Name

Age group (delete those not applicable) 20-30 30-40 40-50 50-60

Employment Location (insert as appropriate): ..... Region

..... Area

..... HG ..... District

Grade Scale (if A & C)

Present job description

Length of time in present job

Professional qualifications

Which (if any) of the courses would not be convenient (delete as appropriate)

Location	Inclusive Dates
Harrogate	20 November 1978 to 1 December 1978
Harrogate	10 December 1978 to 21 December 1978 (nb starting on a Sunday)
Harrogate	8 January 1979 - 19 January 1979

List in order of importance the three subjects in which training is especially sought:-

1. .....
2. .....
3. .....

Signature of RHA/BG nominating officer

APPENDIX 9

National Training Council for the National Health Service
Friars House 157-168 Blackfriars Road London SE1 8EU

Telephone 01-~~407 6522~~ ext 4277
703 6380

Chairman Sir David Perris MBE JP
Secretary V F Jones

Mr D White
Acting Director
Health Services Management Centre
Park House
40 Edgbaston Park Road
BIRMINGHAM B15 2RT

Your reference

Our reference

Date
8 June 1979

Dear Don

INDUSTRIAL RELATIONS TRAINING

You will remember that, on 14 March, representatives of the five National Education Centres met the Working Group on Industrial Relations Training to discuss proposals for a programme of training in industrial relations, including continuing training for personnel specialists. As a result of that meeting you prepared a further paper which was discussed by the Working Group in April and again at a meeting last week.

The Working Group is concerned, as you know, about training on two broad fronts: first, for personnel specialists at all levels, by maintaining the momentum of the courses already arranged; and secondly, carrying industrial relations training to, ultimately, all NHS managers, with all the different levels of need and approach that that implies. Much of the latter programme will, of course, be carried out by authorities themselves rather than be arranged centrally but this is not to say that central advice and support will not be needed, at least initially.

So far, you have expressed an interest in helping with courses for personnel specialists and have outlined proposals on the broader front, subject to additional funding being available, and these interests have been welcomed by the Working Group.

On the question of continuing courses for personnel speicalists, it is estimated that a minimum of ten more courses will be needed over the next two years if demand is to be met, probably with some modification of the course programme to meet slightly different needs which are beginning to emerge. The Working Group would now find it helpful to know what contribution your Centre could make to this objective, with or without additional resources and with or without new initiatives on the broader front. If additional resources would be required, it would be helpful if they could be quantified.

In parallel with provision for personnel staff we have the wider objective of training managers and on this the Working Group have felt that your second paper did not contain sufficient detail to enable them to formulate any recommendation to the Department at this stage. What they need is a discussion of the proposed training programme(s) with an outline of method and approach, details of content and estimated resource implications. If this kind of information can be given for different sections of the programme (for example, if appropriate, training for members of authorities might be assessed separately from that for line management) and perhaps with alternatives on resource implications, this would be most useful

to the Working Group in their task of assessing what can be done and making their recommendations. If any part of the proposed programme could be achieved within existing resources it would be helpful if this were to be stated.

As usual, I am afraid that we are pushed for time, particularly on making arrangements for courses for personnel specialists which we should like to continue in the autumn, and we should be most grateful if you could let us have an early reply, at least on this point. Neither do we wish to delay unduly on the broader issues and on these we should like a reply by 2 July if you can possibly manage it.

I am writing in similar to Brian Edwards at Leicester and Jim Hughes at Manchester and am copying this letter to Stuart Dimmock for information.

We shall look forward to hearing from you.

Yours sincerely

V F JONES
Secretary
Working Group on Industrial
Relations Training

PS Please note that, with effect from Monday 18 June, my address and telephone number will be: Hannibal House, Elephant and Castle, London SE1 6TE; Tel 01-703 6380 Ext 3309.

In Confidence

APPENDIX 10

UNIVERSITY OF BIRMINGHAM

Health Services Management Centre

SEMINAR FOR SENIOR MANAGERS ON INDUSTRIAL ACTION IN THE NHS HELD ON 15th June 1979

The seminar worked in the three syndicate groups who considered three broad areas which make up the key issues in determining management's strategy for coping with industrial action. Syndicate one looked at strategic and policy issues, syndicate two looked at pay issues and syndicate three considered all the remaining non-pay issues.

Syndicate One

Mr P Brearley
Mr A J Brooking (Chairman)
Mr P Castle
Mr P Chubb
Mr J Clark
Mr E B Connors
Mr J Constable
Mr B Smith

Syndicate one considered Policies and Strategies in particular:

1. To what extent should there be a national code of practice?

2. What should be the longer term strategies in respect of industrial action?

3. What is management's accountability - is it to the community, their Authority, or the Secretary of State?

The conclusions of syndicate one were:

1. A national code is desirable in principle although the term strategy or guide line might be more appropriate.

2. The content and scope of national guidelines.

   a) It should be a statement of general philosophy not detailed or rigid.

   b) It should retain local flexibility.

   c) By introducing common factors it would improve the confidence and cohesion of the RHA's and AHA's.

   d) It would probably only be relevant for disputes arising out of one of national issues.

e) Authorities strategies for industrial relations need to be "constantly under review".

f) The DHSS and NHS should agree on broad principles of the National Guidelines.

g) The Guidelines should establish minimum inviolable non-negotiable standards to be maintained by management by what ever means are available. These might for example be in the form of a percentage of the normal volume of patients as agreed with clinicians.

h) The non-negotiable areas must however retain some flexibility so that local management has some option on the tactics to be used.

i) The Guidelines should cover in broad terms issues relating to pay and suspension.

j) The National Guidelines should set down the maximum and minimum variations available to local management but it was appreciated that this might "give the game away" to the staff side.

k) The Guidelines should incorporate a clause relating to the continued application of disciplinary rules for acts of sabotage e.g. switching off a boiler or damaging equipment.

l) The Guidelines should include a statement relating to the payment of stewards with the broad principle that time of the steward which was spent on disruptive action should be unpaid and that communications with members and management should be paid.

m) The Guidelines should contain a statement on communications with full time officers to undermine the power of unofficial staff groups.

n) The principle should be established that clean up payments must not exceed the savings made by management by not paying those involved in the dispute. That is those involved in the dispute must not be seen to make a financial gain from the disruption.

3. Management Accountability.

a) It was recognised that the Secretary of State is ultimately responsible for the NHS.

b) NHS management must carry out the Secretary of State's policies but he may well devolve (actively or by default) responsibility to RHA's and AHA's.

c) Authority members should be involved in formulating long term approaches to industrial relations.

d) Managers should do the negotiating using Authority members as sounding boards and for legitimising their actions.

e) Members must be committed if local policy is to succeed.

f) The NHS should take a lead in improving staff involvement in decision making as a long term strategy for reducing industrial conflict.

Syndicate Two

Miss M Davis (Chairman)
Miss W J Dixon
Mr S P Fletcher
Dr F N Garrett
Mr F Gaston
Mr A Gray
Mr D Hassall

Syndicate two considered pay issues, in particular:

1. What should the policy be with regard to payment for less than full work? and what action should be taken towards implementing these policies?

2. What contingency planning is appropriate?

The conclusions of syndicate two were:

1. a) The principle of no work no pay should be firmly established.

b) Consideration should be given to a policy for lay offs (should those not involved in the dispute suffer financially?)

c) In the case of self selection of duties a case could be made for a strong stand from the start that unless job descriptions (or their custom and practise equivalents) are carried out staff should be sent home until such time as they were willing to work normally.

d) Bonus schemes should be regularly reviewed and should contain clauses relating to industrial action.

e) Bonus scheme payments should cease immediately on industrial action taking place or by phased withdrawal.

f) Management's policy on pay should be widely known so that the ground rules were clearly understood before conflict commenced to avoid the impression of management escalation.

2. Contingency Planning.

a) There were arguments for not going in for detailed contingency plans which might legitimise irresponsible staff action.

b) Contingency planning was necessary for the basic services e.g. CSSD (Central Sterile Supply Department).

c) There were strong arguments for not centralising sources of supply regardless of apparent economies of scale.

Syndicate Three

Mr C L Jackson
Mr J Morrison
Mr E O'Connor
Mr J E Ruch
Mr J S Tharme
Mr K G Walker (Chairman)
Mr P Worsley

Syndicate three considered non-pay issues such as volunteers, admissions policies, clinical freedom, contractors, pickets and contingency planning.

The conclusions of syndicate three were:

1. a) It was important to establish in advance the minimum acceptable level of patient services (the BMA list is relevant in this context).

b) The National Guidelines should legitimise the use of volunteers, contractors etc. to meet this minimum standard - but even this should retain local flexibility.

c) The principle of clinical freedom and the right of the doctor to determine priorities between patients must be preserved.

d) An acceptable volume of patients (i.e. percentage of normal) should be established by multi-disciplinary teams.

e) The legal position regarding picketing needs to be clarified and widely publicised in the service.

f) A policy needs to be established for staff who will not cross picket lines - do they get paid?

g) Contingency planning should make use of existing plans for other forms of crisis (e.g. epidemics).

h) There is a need for managements to identify in advance the organisations vulnerable services.

i) Sources of supply of services should be decentralised.

The seminar concluded with two vital themes:

1. Authorities should create their policies for dealing with the many aspects of industrial action now and not wait for national guidance.

2. National Guidelines were necessary and senior managers in the NHS must work towards their creation in particular by asking their regional administrators to initiate immediate consultation.

APPENDIX II

WEST BIRMINGHAM HEALTH DISTRICT

INDUSTRIAL RELATIONS POLICY

STATEMENT OF DISTRICT INTENT

1.1 The West Birmingham Health District Management Team (hereafter to be known as the D.M.T.), recognises the need to promote and maintain within the District a climate of good industrial relations between management and employees, in order to further their mutual aims concerning the welfare of staff and the service they provide. Foremost amongst these aims is the provision and maintenance of the highest possible standard of health care to the community.

1.2 The D.M.T. accepts the need to conform to such legislation, Health Service policy and guidance and the provisions of the Advisory, Conciliation and Arbitration Service Code of Practice as are relevant and current with regard to industrial relations practice within the District and priorities to meet this need will be set within the available resources.

1.3 As a necessary step to the achievement of good industrial relations, the D.M.T. wishes to establish structures at District and Sector levels to enable effective communications to be maintained between management and staff on issues which are of mutual concern.

1.4 The D.M.T. wishes to review the policy initially after twelve months' operation to ensure its continuing effectiveness.

RECOGNITION

2.1 The D.M.T. accepts that management has a responsibility to take account of the interests of those who belong to recognised associations or trade unions as well as a responsibility to take account of the interests of staff who are not members of recognised organisations. It recognises those staff organisations which have gained national recognition within the Health Service (see attached schedule at appendix 1), which can demonstrate that they have an appropriate level of membership (to be agreed) within the District and will, as far as is appropriate and practical, grant such facilities as are outlined in section 5 below. It reserves the right to withdraw recognition from a staff organisation which loses national recognition.

In accordance with national guidance individuals are encouraged to belong to Associations and Trade Unions recognised by the Whitley Council.

The D.M.T. wishes to formalise its procedure for recognising union officials to ensure a common understanding exists throughout the District.

Consultation should take place as soon as possible between representatives of staff associations and trade unions and management concerning the criteria for according or withdrawing recognition of staff organisations within the District.

continued.....

STAFF CONSULTATION AND NEGOTIATION

3.1 The D.M.T. recognises the increasing importance of the dissemination of information to staff and management, (and will undertake to introduce and/or develop systems to facilitate this), and of the need to consult appropriately on matters affecting the interests of staff within the District. In this respect, the D.M.T. acknowledges the value of staff organisations as a vehicle for staff consultation. It believes that by establishing a formal structure at District and Sector levels. the communication channels should be improved, leading to speedy resolution of problems concerning matters of mutual interest at the lowest appropriate level in the organisation. In respect of individual functions, heads of departments will be required to provide a structure for handling industrial relations matters appropriate to their own spheres of responsibility. The purpose of this will be to deal with issues related only to the department itself.

3.2 The establishment of a formal structure as provided for in paragraph 3.1 above will not remove the right of any individual, trade union or other staff organisation to raise issues direct with departments, sectors or the District where appropriate.

3.3 The D.M.T. awaits a final General Whitley Council Agreement on Joint Staff Consultation Machinery and any changes which may occur with regard to negotiating methods and machinery as a result of the McCarthy Report, "Making Whitley Work". In the interim, it will recognise the District Staff Organisations' Panel as the appropriate body for consultation with staff on District-wide matters. (Proposed Discussion Draft Constitution attached at appendix 2).

3.4 The D.M.T. will create a District Management Industrial Relations Team which will meet the Staff Organisations' Panel for consultative and negotiating purposes at a District Joint Committee. As appropriate, it will support the setting up of Sector Joint Committees at Sector level which will represent management and staff interests in the local situation. Provision will be made on Sector Joint Committees for the attendance of Sector-based personnel who belong to functions, e.g. Works personnel attached to Sectors. (Draft models for this machinery and its composition attached at appendix 3). The Committee structure will not replace the ongoing need for the majority of issues to be settled within a department or function by the line manager and the member or members of staff concerned. The Committees' main functions will be to discuss issues which have Sector or District implications such as those arising in Section 4 below. It is intended that most matters will be resolved at departmental or sector level without reference to the District tier. There will be no line relationship between the tiers in the structure.

3.5 When the machinery at 3.4 above is introduced it will become the responsible forum for management/union/staff consultation but will not remove from Functional Managers their accountability for the provision of consultation within their spheres of control.

PROCEDURE FOR DEALING WITH GRIEVANCES

4 The D.M.T. wishes to establish a jointly agreed procedural agreement to enable the speedy settlement of grievances related to an individual or a group of staff. It considers that the draft Area Grievance Procedure (see appendix 8), will be used as the basis for such an agreement.

continued.... ...

FACILITIES FOR STAFF ORGANISATIONS

5.1 Matters concerning facilities and time off for the duties and activities of trade unions and staff organisations and access to information for the purpose of trade union duties and activities will be handled in accordance with the appendix to Advance Letter GC 2/76 (see appendix 4), and any policy guidelines or agreements which may emanate from the Birmingham Area Health Authority (Teaching), the Codes of Practice of the Advisory, Conciliation and Arbitration Service covering "Time Off for Trade Union Duties and Activities" and the "Disclosure of Information to Trade Unions for Collective Bargaining Purposes" or under any legislation which may be approved from time to time, (see appendices 5 and 6).

5.2 In accordance with the provisions of paragraph 5.1 above, the D.M.T. wishes to make available to staff organisations such facilities as may be reasonable to assist them in carrying out their duties and responsibilities both to and for their membership. It recognises that the requirement for facilities may vary from time to time between staff organisations and between parts of the District, and therefore, wishes to maintain a flexible approach to this issue.

5.3 The D.M.T. shall ensure that there are provided such facilities for the accredited representatives of staff organisations for the promotion of membership recruitment as are consistent with ensuring that no one such organisation is especially advantaged.

5.4 The D.M.T. will agree to such time off for trade union duties and activities as is reasonable under the provisions of paragraph 5.1 above. It believes that guidelines in relation to time off for accredited representatives to carry out their duties should be laid down, based on genuine needs and the exigencies of the Service but recognises that management have a particular responsibility for making arrangements and that co-operation of staff will not be unreasonably withheld on work schedule adjustments to meet these requirements.

5.5 Payments made to accredited representatives attending meetings at the specific request of management outside normal working hours will be in accordance with the provisions laid down in appendix 7.

5.6 Managers at District and Sector level will have responsibility for ensuring that reasonable facilities are provided, reviewing these as necessary. The D.M.T. requires its managers to co-operate in respect of paragraphs 5.2 to 5.5 with regard to the provision of reasonable material facilities, (e.g. office facilities, accommodation for meetings, access to notice boards and help in organising ballots etc.), and the granting of reasonable time off for trade union duties and activities. The granting of material facilities and time off for trade union duties and activities will not become "custom and practice" issues with staff organisations but will vary according to the circumstances. The District Personnel Officer has a responsibility to advise managers on the provision of equitable facilities in the light of prevailing circumstances. It is intended that the issues covered in this section will be the subject of recommendations from the District Joint Committee as soon as possible after its establishment.

continued.....

TRAINING

6.1 The D.M.T. recognises the importance to the Service of adequate training in matters pertaining to industrial relations both for managers and for accredited staff representatives.

6.2 The D.M.T. will seek to support training activities in the area of industrial relations and accepts that the training of managers in this field is a priority. It will provide such time off as is reasonable for the attendance on T.U.C.-approved courses of newly accredited trade union representatives and further training of established representatives. Such time off will always be subject to the exigencies of the Service. (see appendix 6).

6.3 Responsibility for identifying and meeting industrial relations training needs within available finance rests with managers. The District Personnel Officer has a responsibility for providing such assistance as is practicable to enable managers to fulfil this role.

FM/MER
11.1.79

APPENDICES TO I.R. POLICY

1. Bodies recognised nationally for negotiating purposes by Whitley Councils for Health Service and known to have members in Birmingham Area Health Authority (Teaching)

2. Staff Organisations' Panel - Draft Constitution

3. Negotiation/Consultation Structure (attached)

4. Facilities for Staff Organisations

5. Code of Practice: Time Off for Trade Union Duties and Activities

6. Code of Practice: Disclosure of Information to Trade Unions for Collective Bargaining Purposes

7. Payment to Shop Stewards and Staff Representatives attending Meetings whilst off duty

8. Area Grievance Procedure

FM/MER
7.8.80

Annexure 1.3(a)(i)
APPENDIX 12

INDUSTRIAL TRIBUNAL - Mr. P. H. Hitchings.

BACKGROUND

Mr.Hitchings is one of the five Fitters formerly employed at the Cardiff Royal Infirmary, who were dismissed on the 21st May, 1976, and were offered re-employment on the 2nd August, 1976, following a successful appeal to the Health Authority.

Protests were received from the Electrical and Engineering Staff Association representing the Authority's Engineers, at the decision to re-employ the Fitters, and many attempts were made to reconcile the Engineers to this decision, without success.

On the 20th December the Fitters were asked to report for duty; two of them (the most senior) to Cardiff Royal Infirmary, one to the University Hospital of Wales, and one (Mr.Hitchings) to Whitchurch Hospital.

On the same day, the Authority's Engineers withdrew their labour, and the Craftsmen at Whitchurch threatened to walk out if Mr.Hitchings remained at Whitchurch Hospital. Protracted negotiations by the Health Authority's senior officers with all parties to this dispute, failed to produce a solution and, in order to prevent the imminent breakdown of essential main services to Whitchurch Hospital, the Chairman - on behalf of the Health Authority - authorised the dismissal of Mr.Hitchings and an enquiry by A.C.A.S. into the Authority's Disciplinary Procedure (which was conducted in March/April of this year), and gave an assurance to Supervisory Engineers and Managers in other disciplines that they would receive the Authority's full support in the proper exercise of their managerial authority.

This action was confirmed by the Health Authority at its meeting on the 19th January, 1977, when it was also decided that Mr.Hitchings would not be given the right to appeal to the Health Authority against their decision to dismiss him on the grounds -

1. That, in confirming the Chairman's action in dismissing Mr.Hitchings on the basis of his full statement of the circumstances which led him to that point, the Authority have made it impossible for them to provide an independent appeals mechanism to which Mr.Hitchings could have recourse, since the members of the Health Authority were then parties to the decision to dismiss him in the first place.
2. That, bearing in mind that their action in dismissing Mr.Hitchings was taken because of the very strong reaction of the Craftsmen and Engineers to his re-engagement, there was no remedy which they could offer to Mr.Hitchings. The Authority have no powers to compensate

an employee in any other way than by re-instating him and, in the circumstances, his re-instatement was quite clearly out of the question. Since the Authority could not mediate over the employment of Mr.Hitchings, it was considered by the Authority to be in everyone's best interests (including those of Mr.Hitchings) that the issue should be determined by an Industrial Tribunal, should Mr.Hitchings wish to have recourse to that mechanism.

Since Mr.Hitchings' dismissal took effect on the 27th January, 1977, there have been a number of developments. Mr.Hitchings attempted by a number of means to provide himself with the opportunity of an appeal to the Health Authority. An officer of the Confederation of Ship-building Engineering Unions (C.S.E.U.) approached an officer of the Health Authority with the request that a local appeal should be held and, when this was denied, subsequently asked the Welsh Office to convene a meeting at which this request was again pressed. Mr.Hitchings then raised the same matter with his M.P., who took it up with the Permanent Under Secretary of State, who agreed in the light of all the circumstances that an Industrial Tribunal Hearing was the best way of settling the matter. The issue was also raised by Mr.Hitchings with the Cardiff Trades Union Council, of which he is a member, and a deputation from the Council met the Area Personnel Officer on the 26th July to convey their views about Mr.Hitchings' case and the issues of principle which it raised. The notes of that meeting are attached.

Nevertheless, the views of the Authority that the matter could only satisfactorily be resolved by an Industrial Tribunal prevailed, and a hearing took place on the 26/27/28th July.

The Hearing was a long and complex one, and it will be necessary to await the publication in full of the Tribunal's findings in order to fully appreciate the arguments which were put by both parties and the basis on which the Tribunal reached its final conclusion. When the judgement is finally received (probably early in September) I will forward copies to members of the Area Team. However, the principle conclusions of the Tribunal were as follows :

1. That the Authority's dismissal of Mr.Hitchings constituted unfair dismissal under the terms of the Employment Protection Act of 1975. Indeed, this point was conceded by Counsel for the Health Authority in his opening address.

2. That in all the circumstances, it was impracticable for the Health Authority to reinstate Mr.Hitchings. The evidence presented to the Tribunal on the first day, was regarded

by the Tribunal as sufficient to demonstate the impractibility of Mr.Hitchings' re-instatement, and at the end of the first day this point was conceded by Mr. Tal Lloyd, representing Mr.Hitchings, who at that point withdrew his application for re-instatement on Mr.Hitchings' behalf.

3. That during the period of his employment with the Health Authority, Mr.Hitchings contributed substantially to the hostile attitude which was manifested towards him by Engineers and Craftsmen and which culminated in threatened industrial action on the 20th and 21st December, 1976, to such an extent that Mr.Hitchings behaviour was regarded as contributing 60% to the Authority's action in dismissing him in December, 1976.

The Tribunal accordingly made a compensatory order in favour of Mr.Hitchings of approximately £1300 (I regret that I will not have the precise figure until judgement is confirmed), 40% of which represents the sum which the Health Authority will have to pay Mr.Hitchings by way of compensation. It is expected that this figure will not exceed £500; the exact figure should be available by the date of the Health Authority's next formal meeting.

In giving the Tribunal's findings, the Chairman paid tribute to the way in which this complex and difficult case had been presented by Counsel acting for the Health Authority, and by Mr. Tal Lloyd representing Mr.Hitchings. I feel that it would be appropriate for the Health Authority to add its own thanks, not only to Counsel but also to the Legal Department of the Welsh Office, both for the hard work done by the Legal Department in preparing the Authority's case and for the excellence of their Brief to Counsel, which contributed in no small measure to the satisfactory final outcome of this protracted and difficult issue.

We are left with the points made by the Cardiff T.U.C. about the conclusions to be drawn from this episode. Although the Cardiff T.U.C. regard our Disciplinary Procedure as exemplary and accept that the Authority and its senior officers do their best to operate within its provisions at all times, the view has been expressed that in departing from the Procedure to the extent of denying Mr.Hitchings his right to a local appeal hearing, the Authority has shaken trade union confidence in its commitment to abide by negotiated procedural agreements. It was impossible for me to argue in detail the Authority's reasons for this action when I met the representatives of Cardiff T.U.C. on the 20th July, 1977, since one of those representatives was Mr.Hitchings himself and I could not get into discussion about Mr.Hitchings and the unique circumstances of his case without, in a sense, pre-trying and conceivably pre-judging the outcome

of the Industrial Tribunal Hearing. Nevertheless, it would, in my view, be desirable now to convey to Cardiff T.U.C. and to our Staff Organisations as a body, a clear statement of the reasoning which led the Health Authority to depart from the Disciplinary Procedure in the case of Mr.Hitchings, together with a firm undertaking that wherever practicable the Health Authority will invariably abide by the terms of any procedural agreement which it has concluded with Staff Organisations. In so doing, I should be grateful if the Area Team would note carefully the Minutes of my meeting with representatives of the Cardiff Trades Union Council and consider whether any further action is required by the Authority or its officers in the light of comments made at that meeting.

JOHN E. TAYLOR
AREA PERSONNEL OFFICER

3rd August, 1977.

Notes of meeting of deputation from Cardiff TUC and Mr J Taylor at 7.30 pm on Tuesday 26 July 1977 in the Council Chamber, Temple of Peace.

Those present:

Mr T Smith
Mr P Hitchins
Mr C Swain
Mr C Gale
Mr J Taylor
Miss G Crum

1 Mr Smith opened the meeting by stating that via the correspondence between Mr J Taylor and the Secretary of Cardiff TUC, concern was felt that within the framework of the Health Authorities disciplinary procedure anomolies may arise.

2 Whilst the case of Mr Hitchins was considered to be sub judice, the example of Mr Hitchins was to be offered as an example of a perceived anomoly.

3 Referring to Mr Taylor's letter to Mr Swain, Mr Smith stated that contained within that letter was the confirmation that a right of appeal to Mr Hitchins had been refused.

4 The right of the individual was felt to have been undermined, as, despite the existence of a comprehensive procedure, that procedure was ignored.

Referring to the Health Authorities Disciplinary Procedure document, Mr Smith requested clarification of the numbers of complaints received from staff where the procedures as defined had not been followed.

5 Mr Taylor could not confirm that complaints of this type had occurred, indicating that whenever serious or criminal action was perceived to have occurred, suspension was normal, without the provision of prior warnings.

6 Mr Taylor continued to indicate that exact definition of serious criminal acts which would invoke suspension was not possible and that each case had to be considered on its merits.

7 Mr Smith stated that the practice of suspension was not necessarily a problem but the procedure of suspension was of concern to the deputation.

8 Mr Smith continued to question the procedure within the Health Authority, where multi-union representation is endemic, where one union may press for an individual's suspension, whereas another union may request different action.

9 Mr Taylor stated that disciplinary action was not undertaken lightly but that suspension was one method of reducing tension from a situation ie. 'heat' reduction.
Mr Taylor confirmed that inter-union disputes proved most difficult to resolve.

10 Mr Smith enquired whether a written warning could be placed on an employee's file without that employee's knowledge.

11 Mr Taylor confirmed that written warnings, when issued, required confirmation with the staff member or they would not be considered to constitute written warnings.

12 Mr Taylor confirmed that within the disciplinary procedure, any written warnings remained on the individual's personal file for a period not exceeding two years although some warnings remained on record for a lesser period, indicated in the letter of confirmation.

13 Mr Hitchins enquired whether any record was made on an individual's file of suspension which is later found to be unsubstantiated.

14 Mr Taylor stated that investigation of any suspension might result in any of the disciplinary procedures indicated ranging from dismissal to no action. The sole record on the individual's file would be the subsequent action, if any.

15 Mr Swain observed that the deputation were concerned about the possibility of employers compiling 'dossiers' on employees, and requested that where no substantiation was found, no record should be made on the individual's file.

16 Mr Taylor requested that the deputation be clear that there were two separate issues, suspension and written warnings. Warnings are a separate issue and are recorded on individuals' files for a maximum period of two years.

17 Mr Smith enquired about the action of the Health Authority given the situation where an individual following unsubstantiated suspension is directed to work at an alternative location and is received with a hostile view from other staff who refuse to accept the removal of the suspension.

18 Mr Taylor stated that the specific case to which Mr Smith referred was sub judice and as such could not be the subject of discussion.

19 Mr Hitchins referred to the specific case of Mr Beatson whose case was not sub judice.

20 Mr Taylor stated that the decision which was made concerning Mr Beatson had been implemented.

21 Mr Smith questioned the variations of interpretation of a centralised policy which exists throughout the Area.

The specific issue of representation was raised whether individuals were accompanied by a union representative when being interviewed for disciplinary purposes.

22 Mr Taylor confirmed that individuals were given the choice of representation but whenever shop stewards were involved in disciplinary procedure, the District Officer of the relevant union was informed prior to any interview.

23 Mr Swain requested that prior to any disciplinary action being taken against any individual, the relevant District Officer should be informed.

24 Mr Taylor suggested that this procedure would prove impractical but that this was the agreed procedure for shop stewards.

25 Mr Taylor confirmed that approx 75% of ordinary members requested union

representation in any disciplinary interviews but that the 25% who chose not to be represented should be allowed to exercise their prerogative.

26 Mr Hitchins questioned the procedure which arose, if the District Officer of a relevant union, when informed of impending action to be taken against a shop steward, chose not to accompany that shop steward. This action could effectively remove representation from the steward as any representative could only be viewed in the capacity of "friend".

27 Mr Taylor confirmed that the steward has the right to request the presence of his fulltime officer for any disciplinary action.

Mr Taylor continued to confirm that within the disciplinary procedure no appeal was possible against a verbal warning.

28 Mr Smith enquired what recourse was possible for an employee who felt aggrieved about the issue of a verbal warning.

29 Mr Taylor stated that the grievance procedure was available to any individual who was aggrieved by any aspect of his relationship with his supervisor, including the issue of a verbal warning.

30 Mr Swain enquired about the recording of verbal warnings.

31 Mr Taylor confirmed that any recording of verbal warnings would be made informally by the person issuing them, not on the individual's personal file.

Referring to the ACAS document "Report on a diagnostic survey to review the disciplinary procedures of South Glamorgan Health Authority". Mr Taylor confirmed that one suggestion contained therein was the need to improve consistency of recording warnings.

32 Mr Swain stated that because verbal warnings were recorded, some appeal machinery should be available.

33 Mr Taylor suggested that the view of ACAS was that the appeal machinery presently available was too wide ie. that allowing appeal against a reprimand was not contained within Whitley agreement and should not therefore be available locally.

34 Mr Smith stated that under the terms of the disciplinary procedure one major offence was less problematic than a series of minor issues. A further complication could also be seen in the integration of two essentially separate procedures for discipline and grievance.

35 Mr Taylor suggested that widening the range of issues which could be referred to Health Authority members would overload their capacity to cope with hearings and could lead to protracted delays before hearings.

36 Mr Smith maintained that recourse to appeal machinery would necessarily ultimately involve Health Authority members, and fewer complications would arise if employees had earlier recourse to them.

37 Mr Taylor confirmed that he would ensure that further to the earlier discussion (19/20) the recording of any disciplinary action would be in accordance with the procedure as discussed.

38 Mr Hitchins questioned the availability of information concerning the grievance and disciplinary procedures to staff.

39 Mr Taylor confirmed that information was available via all heads of department throughout the Authority.

40 Mr Swain enquired about the availability and circulation of the documents describing Grievance and Disciplinary procedures.

41 Mr Taylor confirmed that they were circulated originally in 1974, then 1976, to all appointing officers, nursing officers and many heads of departments. Copies of all documents were retained in the general office of each Unit.

42 Mr Smith enquired whether this information was available to new employees.

43 Mr Taylor stated that new employees could absorb only a limited amount of procedural information but that all staff were directed to raise enquiries via supervisors or heads of departments, and training and induction courses were available.
It was also confirmed that both procedures were outlined in the staff handbook which is in preparation.

44 Mr Hitchins queried whether the circulation of such documents was to union representatives of <u>all</u> unions, especially those with representation amongst the craft sector.

45 Mr Taylor confirmed that he would contact the District Officers of the craft unions to assist the dissipation of information to shop stewards.

46 Mr Smith queried the availability of appeal machinery if the compulsory transfer of staff members were resisted.
Referring to Mr Taylor's letter to the Cardiff Trades Union Council, wherein was contained confirmation that the right of appeal had been removed from Mr Hitchins, Mr Smith requested comments from Mr Taylor for the Trades Union Council to consider.

47 Mr Swain questioned the role of the Health Authority Chairman in the context of the disciplinary procedure, with reference to Mr Taylor's letter confirming that the decision of the Health Authority could not be varied by him, as an officer.

48 Mr Taylor confirmed that the ACAS investigation was instigated following the industrial action experienced in December 1976. During that investigation ie. March/April 1977, survey was made of all proceedings which had been heard and ACAS found no evidence of departure from the agreed procedure, other than in one case.

Mr Taylor confirmed that the case of Mr Hitchins was unique and was the only occasion upon which the procedure had not been followed. ACAS recommended that the agreed procedure should always be followed, and the AHA accepted that advice.

49 Mr Smith suggested that by accepting the ACAS report, there was an implied

acceptance of criticism of the action of Chairman and Health Authority Membership, and should they not reconsider and convene an appeal hearing?

50 Mr Taylor declined to answer as the case was sub judice.

51 Mr Hitchins suggested than an appeal panel could be convened of members who had not been party to the original decision to refuse right of appeal ie. those who took office subsequent to local authority elections in April 1977.

52 Mr Gale queried the practicality of this suggestion.

53 Mr Taylor declined to answer as the case was sub judice.

54 Mr Hitchins queried the statement made in a letter from Mr Taylor to CSEU that there was no possibility of reinstatement for himself.

55 Mr Smith requested that despite the imminent Industrial Tribunal, Mr Taylor should contact the Health Authority to grant Mr Hitchins the right of appeal.

56 Mr Smith questioned the role of the Chairman of the Health Authority, given the Terms of Reference indicated in the procedural documents, and his stated views.

57 Mr Taylor indicated that the present meeting was not an Industrial Tribunal, but stated that decisions made by the Health Authority were considered and weighed seriously, and that the decisions in question had not been taken lightly.

58 Mr Swain suggested that senior officers of the Health Authority should be exemplary in their actions, and act in their role as "guardians" of the Health Authority. Mr Hitchins, he stated, perceived injustice in the combined action of these officers.

59 Mr Gale suggested that the Health Authority had prejudged the decision of the Industrial Tribunal by Mr Taylor's reference in his letter to CSEU of the Authority's intention not to offer reinstatement to Mr Hitchins.

60 Mr Taylor declined to comment as the case was sub judice.

61 Mr Taylor confirmed that notes of the present meeting would be circulated to the Area Team and to the Chairman, who would no doubt consider what action was required in the light of the comments made.

62 The meeting was closed.

SUMMARY OF RECOMMENDATIONS

78. 1. Clear matters raised on the JSCC without delay. (Para 20)

2. Management should demonstrate their commitment to the JSCC by the inclusion on the agenda of important topics of current interest such as the budget and the control system (Para 20)

3. Arrange for minutes to be accurate and full records of the JSCC discussions. (Para 21)

4. The Trade Unions should demonstrate their commitment to the JSCC and should not let their inter-union problems interfere with the process of joint consultation. (Para 22)

5. Resume JSCC meetings as a matter of urgency. (Para 25)

6. Arrange a training seminar for members of the JSCC. (Para 26)

7. Management and Unions should review the constitution and the working of the JSCC. (Para 26)

8. Establish a formal system of communication. (Para 28)

9. Officers with managerial duties should meet regularly with the Chief Ambulance Officer. (Para 29)

10. Officers with man-management responsibilities should be made aware of their responsibilities for both downward and upward communication between management and staff. (Para 30)

11. Consider the introduction of a News Sheet. (Para 31)

12. Management and unions should discuss and agree the nature and extent of the facilities needed by branch officers and shop stewards to carry out their functions. (Para 34)

13. Issue an agreed Grievance Procedure to all staff (Para 41)

14. Review the function of Station officers and give them the authority to carry out man-management duties. (Para 43)

15. Follow up comments made on work sheets. (Para 46)

16. Review the management structure. (Para 50)

17. Give all levels of management training in industrial relations. (Para 5

18. Train a senior officer to become a specialist in industrial relations and personnel management problemsrelating to the ambulance service. (Para 51)

19. The Area Personnel Department should support the development of the industrial relations/personnel management function in the ambulance service. (Para 52)

20. The Chief Ambulance officer should be given the necessary authority to carry out his responsibilities in relation to consultation and negotiation within the Service. (Para 54)

21. Management and Unions should agree a formal negotiating procedure. (Para 55)

22. Review the role of the Chief Ambulance Officer. (Para 56)

23. Arrange for log book to be available at all times. (Para 66)

24. Consider notifying shop stewards of crew shortages at beginning of shift. (Para 66)

25. Management and Unions should agree on the method to be used in recording the efforts made by management to find replacement crews. (Para 67)

26. Improve station working conditions at Blackweir, Barry and Whitchurch (Para 70)

27. Discuss the promotions procedure on JSCC. (Para 71)

28. Discuss the need to review the present control system. (Para 72)